# U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
# Health Resources and Services Administration

## Maternal and Child Health Bureau
## Division of Research, Training and Education
## Maternal and Child Health Training Program

***Leadership Education in Adolescent Health***

**Announcement Type:** New, Competing Continuation
**Announcement Number:** HRSA-12-015

**Catalog of Federal Domestic Assistance (CFDA) No. 93.110**

**FUNDING OPPORTUNITY ANNOUNCEMENT**

Fiscal Year 2012

## Application Due Date: March 16, 2012

*Ensure your Grants.gov registration and passwords are current immediately!*
*Deadline extensions are not granted for lack of registration.*
*Registration may take up to one month to complete.*

**Release Date: February 15, 2012**
**Issuance Date: February 15, 2012**

**Modified February 23, 2012 to include information regarding the Technical Assistance call scheduled for Friday, February 24, 2012.**

Christopher Dykton
Project Officer
Division of Research, Training, and Education
HRSA Maternal and Child Health Bureau (MCHB)
E-Mail: cdykton@hrsa.gov
Telephone: (301) 443-9534
Fax: (301) 443-4842

Authority: Social Security Act, Title V, §501(a)(2), (42 U.S.C. 701(a)(2))

## EXECUTIVE SUMMARY

Thank you for your interest in applying for the Leadership Education in Adolescent Health (LEAH) Program. Grant support is available from the Division of Research, Training and Education (DRTE), part of the Maternal and Child Health Bureau (MCHB) of the Health Resources and Services Administration (HRSA) in the U.S. Department of Health and Human Services (HHS). We are aware that preparation of this application will involve a considerable commitment of time and energy. Please read the funding opportunity announcement carefully before completing the application.

**Purpose**:
The Leadership Education in Adolescent Health (LEAH) Training Program provides interdisciplinary leadership training for at least five (5) core professional disciplines in the areas of adolescent medicine, psychology, nursing, nutrition and social work at the graduate and postgraduate levels to prepare trainees for leadership roles in clinical services, research, training, and organization of health services for adolescents, including those with special health care needs. The training is designed to integrate biological, developmental, mental health, social, economic, educational, and environmental issues within a public health framework. LEAH projects develop, enhance, and improve adolescent-centered/family-involved, culturally competent, community-based care for adolescents by providing interdisciplinary leadership training of health professionals and by working with state and local health, education, youth development, and human service agencies and providers – public, private, and voluntary – with a maternal and child health focus. These training projects influence the health and health care issues of adolescents nationally.

**Eligibility**:
As cited in 42 CFR Part 51a.3(b), only public or nonprofit private institutions of higher learning may apply for training grants.

**Administrative Preference**:
Preference will be given to Departments of Pediatrics and Internal Medicine of accredited U.S. Medical Schools or to pediatric teaching hospitals having formal affiliations with schools of medicine.

**Number of Grants and Funds Available per Year**:
Up to $2,588,776 may be available to fund up to seven (7) LEAH grants. Subject to the availability of funds and certain limitations as further described below, it is anticipated that the **mean** grant award will be approximately $369,825 per budget period for up to five (5) years. Applicants may apply for a ceiling amount of up to $441,155 per year. In the year in which a training program hosts the annual meeting, the award ceiling amount is $471,155.

**Project Period:**
Approved projects will have a budget period start date of July 1, 2012. Applicants responding to this announcement may request funding for a project period of up to five (5) years.

**Application Due Date:** March 16, 2012

**Technical Assistance Conference Call/Webinar:** Within three weeks of the release of this funding opportunity announcement, a technical assistance conference call or webinar will be conducted to answer questions about the guidance for potential applicants. Contact the project officer noted below for details of this technical assistance session.

**Programmatic Assistance**

Additional information related to the overall program issues or technical assistance may be obtained by contacting:

Christopher Dykton
Project Officer
Division of Research, Training, and Education
HRSA, Maternal and Child Health Bureau (MCHB)
5600 Fishers Lane, Room 18A-55
Rockville, MD 20857
E-Mail: cdykton@hrsa.gov
Telephone: (301) 443-9534
Fax: (301) 443-4842

**Business, Administrative and Fiscal Inquiries**

Applicants may obtain additional information regarding business, administrative, or fiscal issues related to this funding opportunity announcement by contacting:

Pam Bell
Grants Management Specialist
HRSA, Division of Grants Management Operations
5600 Fishers Lane, Room 11A-02
Rockville, MD 20857
E-mail: PBell@hrsa.gov
Telephone: (301) 443-3504
Fax: (301) 443-6686

## Table of Contents

# I. Funding Opportunity Description

## 1. Purpose

The Leadership Education in Adolescent Health (LEAH) Training Program provides interdisciplinary leadership training for at least five (5) core professional disciplines in the areas of adolescent medicine, psychology, nursing, nutrition and social work at the graduate and postgraduate levels to prepare trainees for leadership roles in clinical services, research, training, and organization of health services for adolescents, including those with special health care needs. The training is designed to integrate biological, developmental, mental health, social, economic, educational, and environmental issues within a public health framework. LEAH projects develop, enhance, and improve adolescent-centered/family-involved, culturally competent, community-based care for adolescents by providing interdisciplinary leadership training of health professionals and by working with state and local health, education, youth development, and human service agencies and providers – public, private, and voluntary – with a maternal and child health focus. These training projects influence the health and health care issues of adolescents nationally.

## 2. Background

**This program is authorized by the** Social Security Act, Title V, §501(a)(2), (42 U.S.C. 701(a)(2)).

**Maternal and Child Health Bureau and Title V of the Social Security Act**
In 1935, Congress enacted Title V of the Social Security Act authorizing the Maternal and Child Health Services Programs. This legislation has provided a foundation and structure for assuring the health of mothers and children in the nation for over 75 years. Title V was designed to improve health and assure access to high quality health services for present and future generations of mothers, infants, children and adolescents, including those with disabilities and chronic illnesses, with special attention to those of low income or with limited availability of health services.

Today, Title V is administered by the Maternal and Child Health Bureau (MCHB), which is a part of the Health Resources and Services Administration (HRSA) in the U.S. Department of Health and Human Services (HHS). Under Title V of the Social Security Act, the Maternal and Child Health Services Block Grant program has three components—Formula Block Grants to States, Special Projects of Regional and National Significance (SPRANS) and Community Integrated Service Systems (CISS) grants. Using these authorities, the MCHB has forged partnerships with states, the academic community, health professionals, advocates, communities and families to better serve the needs of the nation's children.

The mission of MCHB is to provide national leadership, in partnership with key stakeholders, to improve the physical and mental health, safety and well-being of the maternal and child health (MCH) population which includes all of the nation's women, infants, children, adolescents, and their families, including fathers and children with special health care needs (CSHCN).

**New Emphasis in MCHB on Life Course Model as a Strategic Organizing Framework**
On October 20, 2010, MCHB released a draft concept paper on the Life Course Model to inform the development of MCHB's next 5 year Strategic Plan. Life course development points to broad social, economic and environmental factors as underlying contributors to poor health and developmental outcomes for all children; including children with special health care needs. It also focuses on persistent disparities in the health and well-being of children and families. The socio-ecological framework emphasizes that children develop within families, families exist within a community, and the community is surrounded by a larger society. These systems interact with and influence each other to either decrease or increase risk factors or protective factors that affect a range of health and social outcomes.

**The Maternal and Child Health Training Program (MCHTP)**
The Maternal and Child Health Training Program is housed within the Maternal and Child Health Bureau's Division of Research, Training and Education (DRTE). MCHTP provides leadership and direction in educating and training our nation's future leaders in maternal and child health.

**MCH Training Program Goals**
MCHTP's vision for the 21st century is that all children, youth, and families will live and thrive in healthy communities served by a quality workforce that helps assure their health and well being. To achieve this vision, the MCHTP is in the process of revising its strategic plan for 2012-2020, which should be finalized in 2012. The goals drafted for this strategic plan to date are:

- Goal 1: Engage, develop, and support accountable MCH leaders.
- Goal 2: Generate, translate, and integrate new knowledge, emerging technologies and promising strategies into innovations in MCH training, policy and practice.
- Goal 3: Prepare and empower MCH leaders to promote health equity, wellness, and reduce disparities in health and healthcare.
- Goal 4: Increase outreach, visibility, and utilization of the expertise and products of the MCH community.
- Goal 5: Promote the health of MCH populations through collaboration, where MCH professionals strategically engage and invest in Title V programs and stakeholders to promote the health of MCH populations through science and service.
- Goal 6: Promote systems of ongoing assessment and continuous improvement that demonstrate the value (quality, efficiency, and outcomes) of MCH professional development in shaping professionals who are well equipped to enhance the health of the population over the life course.

The MCHTP achieves these goals by supporting:

- *Trainees* who show promise to become leaders in the MCH field in the areas of teaching, research, clinical practice, and/or administration and policymaking.
- *Faculty* in public and private nonprofit institutions of higher learning who teach and mentor trainees and students in exemplary MCH public health practice, advance the field through research and dissemination of findings, develop curricula particular to MCH and public health, and provide technical assistance to the field.

- *Continuing education and technical assistance* to those already practicing in the MCH field to keep them abreast of the latest research and emerging better practices.

**Rationale for the LEAH Competition**

As the executive summary of the 2009 National Academies of Sciences (NAS) report "Adolescent Health: Missing Opportunities" notes,

> Adolescence is a time of major transitions, when young people develop many of the habits, patterns of behavior, and relationships they will carry into their adult lives. Most adolescents in the United States are healthy. But many engage in risky behavior, develop unhealthful habits, or have chronic conditions that can jeopardize their immediate health and safety and contribute to poor health in future years. [1]

The report details how the health system is tasked with health promotion, disease prevention and primary and preventive care for the youth of the United States, but that current systems of health care are not appropriately customized for adolescents and those health care providers are not trained on adolescent health care issues. As adolescents become adults, an important need exists to design systems of health that engage adolescents directly and create developmentally appropriate opportunities to address adolescent health and behavioral health care. The NAS report identifies the national need for the development of maternal and child health leaders to address adolescent health workforce gaps and to help address the lack of needed skills in health care professionals working on adolescent health issues.

Data reported by the states demonstrate the need for training MCH leaders in adolescent health to meet the priority needs of the states. In 2010, the 59 states and jurisdictions conducted their five-year needs assessments, and the priority needs that states identified prominently featured adolescent health issues. Of the 59 states and jurisdictions funded under the Title V Block Grant, 50 states identified at least one priority focusing on adolescent health.[2] Of the 535 priority needs identified across the states and jurisdictions, 24.1% (129) focus on issues that are important to adolescent health, such as access to primary and preventive health and specialty care; nutrition, particularly around overweight and obesity; mental health; risk factors associated with tobacco and substance use; reproductive health; and, injury prevention. The status of adolescent health in the U.S. continues to be a public health challenge. As the Department of Health and Human Services (HHS) notes in its summary of adolescent health in Healthy People 2020, adolescents and young adults are sensitive to environmental influences. Environmental factors, including family, peer group, school, neighborhood, policies, and societal cues, can either support or challenge young people's health or well-being.[3] Developing leaders and a work force to address these adolescent health care issues are at the center of addressing this public health need.

This need is also echoed in the federal government's development of the Healthy People (HP) 2020 objectives, where for the first time, a topic area on improving the healthy development, health, safety, and well-being of adolescents and young adults, was identified as separate from

---

1 United States, Committee on Adolescent Health Care Services and Models of Care for Treatment, Prevention, and Healthy Development, National Academy of Science, Adolescent Health Services: Missing Opportunities. (Washington, DC: The National Academy Press, 2009).

[2] Title V Information System, https://perfdata.hrsa.gov/MCHB/TVISReports/default.aspx

[3] Healthy People 2020 Web site, Adolescent Health, http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=2

the healthy development of children. HP 2020 notes that adolescents (ages 10 to 19) and young adults (ages 20 to 24) make up 21 percent of the population of the United States.[4] The behavioral patterns established during these developmental periods help determine young people's current health status and their risk for developing chronic diseases in adulthood.[5]

Developing leaders in maternal and child health to help train the next generation of adolescent health professionals in various disciplines, is a priority in addressing adolescent health. Further, adolescent health professionals need to work in an interdisciplinary way to ensure that the various physical, social, psychological and emotional, familial, and environmental needs and services for adolescents are coordinated and integrated.

A major finding of the NAS report is the recommendation that public and private funders need to ensure that professionals who serve adolescents in health care settings are trained in:

1) how to relate to adolescents and gain their trust and cooperation;
2) how to develop strong provider–patient relationships;
3) how to identify early signs of risky and unhealthful behavior that may require further assessment, intervention, or referral; and
4) how to work with more vulnerable adolescents, such as those who are in the lesbian, gay, bisexual, or transgender; homeless; foster care system; the juvenile justice system; and in families that have recently immigrated to the United States.[6]

The MCH LEAH Training Program addresses these challenging training issues. It provides interdisciplinary leadership training for at least five (5) core professional disciplines in the areas of adolescent medicine, psychology, nursing, nutrition and social work at the graduate and postgraduate levels to prepare trainees for leadership roles in personal health and public health care systems, including clinical services, research, training, and development of health services for adolescents, including those with special health care needs.

The training is designed to integrate biological, developmental, mental health, social, economic, educational, and environmental issues within a public health framework. In addition, the LEAH program trains leaders prepared to work in research, teaching, clinical, policy, and advocacy efforts around systems change supporting maternal and child health and this training emphasizes collaborating with and supporting national and state MCH efforts overall.

LEAH programs develop, enhance, and improve adolescent-centered/family-involved, culturally competent, community-based care for adolescents by providing interdisciplinary leadership training of health professionals and by working with state and local health, educational, and social service agencies and providers, and thus influencing the local, regional and national adolescent health issues.

---

[4] U.S. Census Bureau. 2008 population estimates: National characteristics, national sex, age, race and Hispanic origin. Washington: 2008. Available from: http://www.census.gov/popest/national/asrh/NC-EST2008-asrh.html

[5] United States, Committee on Adolescent Health Care Services and Models of Care for Treatment, Prevention, and Healthy Development, National Academy of Science, Adolescent Health Services: Missing Opportunities. (Washington, DC: The National Academy Press, 2009).

[6] United States, Committee on Adolescent Health Care Services and Models of Care for Treatment, Prevention, and Healthy Development, National Academy of Science, Adolescent Health Services: Missing Opportunities. (Washington, DC: The National Academy Press, 2009).

# II. Award Information

## 1. Type of Award

Funding will be provided in the form of a grant.

## 2. Summary of Funding

This program will provide funding during federal fiscal years 2012–2016. Approximately $2,588,776 is expected to be available annually to fund up to seven (7) grantees. Based on historical data and expected funding levels, it is anticipated that the mean grant award will be approximately $369,825. Applicants may apply for a ceiling amount of up to $441,155 per year. In the year in which a training program hosts the annual meeting, the award ceiling amount is $471,155. The project period is five (5) years. Funding beyond the first year is dependent on the availability of appropriated funds for the LEAH program in subsequent fiscal years, satisfactory grantee performance, and a decision that continued funding is in the best interest of the Federal Government.

# III. Eligibility Information

## 1. Eligible Applicants

As cited in 42 CFR Part 51a.3(b), only public or nonprofit private institutions of higher learning may apply for training grants.

## 2. Cost Sharing/Matching

There is no cost sharing or matching requirement for this program.

## 3. Other

Applications that exceed the ceiling amount will be considered non-responsive and will not be considered for funding under this announcement.

Any application that fails to satisfy the deadline requirements in *Section IV.3* will be considered non-responsive and will not be considered for funding under this announcement.

See Appendix B for information regarding Trainee/Fellow eligibility.

NOTE: Multiple applications from an organization are not allowable. For example, an organization/institution with various PI's who might want to submit an application each for this funding opportunity.

# IV. Application and Submission Information

## 1. Address to Request Application Package

**Application Materials and Required Electronic Submission Information**
HRSA ***requires*** applicants for this funding opportunity announcement to apply electronically through Grants.gov. This robust registration and application process protects applicants against fraud and ensures that only authorized representatives from an organization can submit an application. Applicants are responsible for maintaining these registrations, which should be completed well in advance of submitting your application. All applicants ***must*** submit in this manner unless they obtain a written exemption from this requirement in advance by the Director of HRSA's Division of Grants Policy. Applicants must request an exemption in writing from **DGPWaivers@hrsa.gov**, and provide details as to why they are technologically unable to submit electronically through the Grants.gov portal. Your email must include the HRSA announcement number for which you are seeking relief, the organization's DUNS number, the name, address, and telephone number of the organization and the name and telephone number of the Project Director as well as the Grants.gov Tracking Number (GRANTXXXX) assigned to your submission along with a copy of the "Rejected with Errors" notification you received from Grants.gov. **HRSA and its Digital Services Operation (DSO) will only accept paper applications from applicants that received prior written approval.** However, the application must still be submitted by the deadline. Suggestion: submit application to Grants.gov at least two days before the deadline to allow for any unforeseen circumstances.

Note: Central Contractor Registration (CCR) information must be updated at least every 12 months to remain active (for both grantees and sub-recipients). As of August 9, 2011, Grants.gov began rejecting submissions from applicants with expired CCR registrations. Although active CCR registration at time of submission is not a new requirement, this systematic enforcement will likely catch some applicants off guard. According to the CCR Website it can take 24 hours or more for updates to take effect, so ***check for active registration well before your grant deadline.***

An applicant can view their CCR Registration Status by visiting http://www.bpn.gov/CCRSearch/Search.aspx and searching by their organization's DUNS. The CCR Website provides user guides, renewal screen shots, FAQs and other resources you may find helpful.

Applicants that fail to allow ample time to complete registration with CCR and/or Grants.gov will not be eligible for a deadline extension or waiver of the electronic submission requirement.

All applicants are responsible for reading the instructions included in HRSA's *Electronic Submission User Guide*, available online at http://www.hrsa.gov/grants/apply/userguide.pdf. This Guide includes detailed application and submission instructions for both Grants.gov and HRSA's Electronic Handbooks. Pay particular attention to Sections 2 and 5 that provide detailed information on the competitive application and submission process.

Applicants must submit proposals according to the instructions in the Guide and in this funding opportunity announcement in conjunction with Application Form 424 Research and Related (SF-424 R&R). The forms contain additional general information and instructions for applications, proposal narratives, and budgets. The forms and instructions may be obtained by:

1) Downloading from http://www.grants.gov, or

2) Contacting the HRSA Digital Services Operation (DSO) at: HRSADSO@hrsa.gov

Each funding opportunity contains a unique set of forms and only the specific forms package posted with an opportunity will be accepted for that opportunity. Specific instructions for preparing portions of the application that must accompany Standard Form 424 Research and Related (SF-424 R&R) appear in the "Application Format Requirements" section below.

## 2. Content and Form of Application Submission

### Application Format Requirements

The total size of all uploaded files may not exceed the equivalent of 80 pages when printed by HRSA. The total file size may not exceed 10 MB. The 80-page limit includes the abstract, project and budget narratives, attachments, and letters of commitment and support. Standard forms are NOT included in the page limit. **We strongly urge you to print your application to ensure it does not exceed the 80-page limit. Do not reduce the size of the fonts or margins to save space. See the formatting instructions in Section 5 of the Electronic Submission User Guide referenced above.**

**Applications must be complete, within the 80-page limit, within the 10 MB limit, and submitted prior to the deadline to be considered under this announcement.**

### Application Format

Applications for funding must consist of the following documents in the following order:

# SF-424 R&R – Table of Contents

- **It is mandatory to follow the instructions provided in this section to ensure that your application can be printed efficiently and consistently for review.**
- **Failure to follow the instructions may make your application non-responsive. Non-responsive applications will not be considered under this funding opportunity announcement.**
- For electronic submissions, applicants only have to number the electronic attachment pages sequentially, resetting the numbering for each attachment, i.e., start at page 1 for each attachment. Do not attempt to number standard OMB approved form pages.
- For electronic submissions, no Table of Contents is required for the entire application. HRSA will construct an electronic table of contents in the order specified.

| Application Section | Form Type | Instruction | HRSA/Program Guidelines |
|---|---|---|---|
| SF-424 R&R Cover Page | Form | Pages 1 & 2. | Not counted in the page limit. |
| Pre-application | Attachment | Can be uploaded on page 2 of SF-424 R&R - Box 20. | Not Applicable to HRSA; Do not use. |
| SF-424 R&R Senior/Key Person Profile | Form | Supports 8 structured profiles (PD + 7 additional) | Not counted in the page limit. |
| Senior Key Personnel Biographical Sketches | Attachment | Can be uploaded in SF-424 R&R Senior/Key Person Profile form or other text format. One per each senior/key person. The PD/PI biographical sketch should be the first biographical sketch. Up to 8 allowed. | Counted in the page limit. |
| Senior Key Personnel Current and Pending Support | Attachment | Can be uploaded in SF-424 R&R Senior/Key Person Profile form. | Not Applicable to HRSA; Do not use. |
| Additional Senior/Key Person Profiles | Attachment | Can be uploaded in SF-424 R&R Senior/Key Person Profile form. Single document with all additional profiles. | Not counted in the page limit. |
| Additional Senior Key Personnel Biographical Sketches | Attachment | Can be uploaded in the Senior/Key Person Profile form. Single document with all additional sketches. | Counted in the page limit. |
| Additional Senior Key Personnel Current and Pending Support | Attachment | Can be uploaded in the Senior/Key Person Profile form. | Not Applicable to HRSA; Do not use. |
| Project/Performance Site Location(s) | Form | Supports primary and 29 additional sites in structured form. | Not counted in the page limit. |
| Additional Performance Site Location(s) | Attachment | Can be uploaded in SF-424 R&R Performance Site Location(s) form. Single document with all additional site location(s). | Not counted in the page limit. |
| Other Project Information | Form | Allows additional information and attachments. | Not counted in the page limit. |
| Project Summary/Abstract | Attachment | Can be uploaded in SF-424 R&R Other Project Information form, Box 6. | Required attachment. Counted in the page limit. Refer to funding opportunity |

| | | | |
|---|---|---|---|
| | | | announcement for detailed instructions. Provide table of contents specific to this document only as the first page. |
| Project Narrative | Attachment | Can be uploaded in SF-424 R&R Other Project Information form, Box 7. | Required attachment. Counted in the page limit. Refer to funding opportunity announcement for detailed instructions. Provide table of contents specific to this document only as the first page. |
| SF-424 R&R Budget Period (1-5) - Section A – B | Form | Supports structured budget for up to 5 periods. | Not counted in the page limit. |
| Additional Senior Key Persons | Attachment | SF-424 R&R Budget Period (1-5) - Section A - B, End of Section A. One for each budget period. | Not counted in the page limit. |
| SF-424 R&R Budget Period (1-5) - Section C – E | Form | Supports structured budget for up to 5 periods. | Not counted in the page limit. |
| Additional Equipment | Attachment | SF-424 R&R Budget Period (1-5) - Section C – E, End of Section C. One for each budget period. | Not counted in the page limit. |
| SF-424 R&R Budget Period (1-5) - Section F – K | Form | Supports structured budget for up to 5 periods. | Not counted in the page limit. |
| SF-424 R&R Cumulative Budget | Form | Total cumulative budget. | Not counted in the page limit. |
| Budget Justification | Attachment | Can be uploaded in SF-424 R&R Budget Period (1-5) - Section F - J form, Box K. Only one consolidated budget justification for the project period. | Required attachment. Counted in the page limit. Refer to funding opportunity announcement for detailed instructions. Provide table of contents specific to this document only as the first page. |
| SF-424 R&R Subaward Budget | Form | Supports up to 10 budget attachments. This form only contains the attachment list. | Not counted in the page limit. |
| Subaward Budget Attachment 1-10 | Attachment | Can be uploaded in SF-424 R&R Subaward Budget form, Box 1 through 10. Extract the form from the SF-424 R&R Subaward Budget form and use it for each consortium/ contractual/subaward budget as required by the program funding opportunity announcement. Supports up to 10. | Filename should be the name of the organization and unique. Not counted in the page limit. |
| SF-424B Assurances for Non-Construction Programs | Form | Assurances for the SF-424 R&R package. | Not counted in the page limit. |
| Bibliography & References | Attachment | Can be uploaded in Other Project Information form, Box 9. | Required. Counted in the page limit. |
| Facilities & Other Resources | Attachment | Can be uploaded in Other Project Information form, Box 10. | Optional. Counted in the page limit. |
| Equipment | Attachment | Can be uploaded in Other Project Information | Optional. Counted in the page limit. |

| | | | |
|---|---|---|---|
| | | form, Box 11. | |
| Disclosure of Lobbying Activities (SF-LLL) | Form | Supports structured data for lobbying activities. | Not counted in the page limit. |
| Other Attachments Form | Form | Supports up to 15 numbered attachments. This form only contains the attachment list. | Not counted in the page limit. |
| Attachment 1-15 | Attachment | Can be uploaded in Other Attachments form 1-15. | Refer to the attachment table provided below for **specific** sequence. Counted in the page limit. |
| Other Attachments | Attachment | Can be uploaded in SF-424 R&R Other Project Information form, Box 12. Supports multiple. | Not Applicable to HRSA; Do not use. |

- **To ensure that attachments are organized and printed in a consistent manner, follow the order provided below. Note that these instructions may vary across programs.**
- Evidence of Non-Profit status and invention related documents, if applicable, must be provided in the other attachment form.
- Additional supporting documents, if applicable, can be provided using the available rows. Do not use the rows assigned to a specific purpose in the program funding opportunity announcement.
- Merge similar documents into a single document. Where several documents are expected in one attachment, ensure that you place a table of contents cover page specific to the attachment. Table of Contents page will not be counted in the page limit.
- Limit the file attachment name to under 50 characters. Do not use any special characters (e.g., %, /, #) or spacing in the file name or word separation. (The exception is the underscore ( _ ) character.) Your attachment will be rejected by Grants.gov if you use special characters or attachment names greater than 50 characters.

| Attachment Number | Attachment Description (Program Guidelines) |
|---|---|
| Attachment 1 | Chart/Table of Partners and Collaboration. All items specified in Section IV.2.xi. must be identified in this section. |
| Attachment 2 | Map(s) |
| Attachment 3 | Organizational Chart(s) |
| Attachment 4 | Curriculum |
| Attachment 5 | Position Descriptions of Key Personnel |
| Attachment 6 | Summary Progress Report – for COMPETING CONTINUATIONS ONLY (Limit to 20 pages). These pages in the progress report WILL be counted in the 80 page limit. |
| Attachments 7–15 | Other relevant documents, such as budgets and budget justifications for subcontracts, etc. |

## Application Format

### i. *Application Face Page*

Complete Standard Form 424 Research and Related (SF-424 R&R) provided with the application package. Prepare according to instructions provided in the form itself. For information pertaining to the Catalog of Federal Domestic Assistance, the CFDA Number is 93.110.

### DUNS Number

All applicant organizations (and subrecipients of HRSA award funds) are required to have a Data Universal Numbering System (DUNS) number in order to apply for a grant or cooperative agreement from the Federal Government. The DUNS number is a unique nine-character identification number provided by the commercial company, Dun and Bradstreet. There is no charge to obtain a DUNS number. Information about obtaining a DUNS number can be found at http://fedgov.dnb.com/webform or call 1-866-705-5711. Please include the DUNS number in SF424 R&R – item 5 on the application face page. Applications ***will not*** be reviewed without a DUNS number. Note: A missing or incorrect DUNS number is the number one reason for applications being "Rejected for Errors" by Grants.gov. HRSA will not extend the deadline for applications with a missing or incorrect DUNS number. Applicants should take care in entering the DUNS number in the application.

Additionally, the applicant organization (and any subrecipient of HRSA award funds) is required to register annually with the Central Contractor Registration (CCR) in order to do electronic business with the Federal Government. CCR registration must be maintained with current, accurate information at all times during which an entity has an active award or an application or plan under consideration by HRSA. It is extremely important to verify that your CCR registration is active and your Marketing Partner ID Number (MPIN)is current. Information about registering with the CCR can be found at http://www.ccr.gov.

### ii. *Table of Contents*

The application should be presented in the order of the Table of Contents provided earlier. Again, for electronic applications no table of contents is necessary as it will be generated by the system. (Note: the Table of Contents will not be counted in the page limit.)

### iii. *Budget*

Complete the Research and Related Budget Form provided with the application package.

Please complete the Research & Related Budget Form (Sections A – J and the Cumulative Budget) for each budget period. Upload the Budget Justification Narrative for the entire project period (all budget periods) in Section K of the Research & Related Budget Form. Following completion of Budget Period 1, you must click on the "NEXT PERIOD" button on the final page to allow for completion of Budget Period 2. You will repeat this instruction to complete Budget Periods 3, 4, and 5.

The Cumulative Budget is automatically generated and provides the total budget information for the five-year grant request. Errors found in the Cumulative Budget must be corrected within the incorrect field(s) in Budget Period 1, 2, 3; 4 or 5 corrections cannot be made to the Cumulative Budget itself.

Awards are subject to adjustment after program and peer review. If this occurs, program components and/or activities will be negotiated to reflect the final award.

**Salary Limitation:**
The Consolidated Appropriations Act, 2012 (P.L. 112-74) enacted December 23, 2011, limits the salary amount that may be awarded and charged to HRSA grants and cooperative agreements. Award funds may not be used to pay the salary of an individual at a rate in excess of Executive Level II. The Executive Level II salary of the Federal Executive Pay scale is $179,700. This amount reflects an individual's base salary exclusive of fringe and any income that an individual may be permitted to earn outside of the duties to the applicant organization. This salary limitation also applies to subawards/subcontracts under a HRSA grant or cooperative agreement.

As an example of the application of this limitation: If an individual's base salary is $350,000 per year plus fringe benefits of 25% ($87,500) and that individual is devoting 50% of their time to this award, their base salary should be adjusted to $179,700 plus fringe of 25% ($44,925) and a total of $112,312.50 may be included in the project budget and charged to the award in salary/fringe benefits for that individual. See the breakdown below:

| | |
|---|---|
| Individual's *actual* base full time salary: $350,000<br>50% of time will be devoted to project | |
| Direct salary | $175,000 |
| Fringe (25% of salary) | $43,750 |
| Total | $218,750 |
| **Amount that may be claimed on the application budget due to the legislative salary limitation:**<br>Individual's base full time salary *adjusted* to Executive Level II: $179,700<br>50% of time will be devoted to the project | |
| Direct salary | **$89,850** |
| Fringe (25% of salary) | **$22,462.50** |
| Total amount | **$112,312.50** |

**iv. *Budget Justification***
Provide a narrative that explains the amounts requested for each line in the budget. The budget justification must specifically describe how each item will support the achievement of proposed objectives. The budget period is for ONE year. However, the applicant **must** submit one-year budgets for each of the subsequent budget periods within the requested project period at the time of application. Line item information must be provided to explain the costs entered in the SF-424 Research and Related budget form. Clearly describe how each item in the "other" category is justified. For subsequent budget years, the justification narrative should highlight the changes from year one or clearly indicate that there are no substantive budget changes during the project period. The budget justification MUST be concise. Do NOT use the justification to expand the project narrative.

**Budget for Multi-Year Award**
This announcement is inviting applications for project periods up to five (5) years. Awards, on a competitive basis, will be for a one-year budget period; although the project period may be for up to five (5) years. Submission and HRSA approval of your Progress Report(s) and any other required submission or reports is the basis for the budget period renewal and release of

subsequent year funds. Funding beyond the one-year budget period but within the five-year project period is subject to availability of funds, satisfactory progress of the awardee, and a determination that continued funding would be in the best interest of the Federal Government.

Include the following in the Budget Justification narrative:

*Personnel Costs:* Personnel costs should be explained by listing each staff member who will be supported from funds, name (if possible), position title, percentage of full-time equivalency, and annual salary. Reminder: Award funds may not be used to pay the salary of an individual at a rate in excess of Executive Level II or $179,700. An individual's base salary, per se, is NOT constrained by the legislative provision for a limitation of salary. The rate limitation simply limits the amount that may be awarded and charged to HRSA grants and cooperative agreements. Please provide an individual's actual base salary if it exceeds the cap. See the sample below.

Sample:

| Name | Position Title | % of FTE | Annual Salary | Amount Requested |
|---|---|---|---|---|
| J. Smith | Chief Executive Officer | 50 | $179,700* | $89,850 |
| R. Doe | Nurse Practitioner | 100 | $75,950 | $75,950 |
| D. Jones | Data/AP Specialist | 25 | $33,000 | $8,250 |

*Actual annual salary = $350,000

*Fringe Benefits:* List the components that comprise the fringe benefit rate, for example health insurance, taxes, unemployment insurance, life insurance, retirement plans, and tuition reimbursement. The fringe benefits should be directly proportional to that portion of personnel costs that are allocated for the project. (If an individual's base salary exceeds the legislative salary cap, please adjust fringe accordingly.)

*Travel:* List travel costs according to local and long distance travel. For local travel, the mileage rate, number of miles, reason for travel and staff member/consumers completing the travel should be outlined. The budget should also reflect the travel expenses associated with participating in meetings and other proposed trainings or workshops, including two faculty attending the annual meeting.

*Equipment:* List equipment costs and provide justification for the need of the equipment to carry out the program's goals. Extensive justification and a detailed status of current equipment must be provided when requesting funds for the purchase of computers and furniture items that meet the definition of equipment (a unit cost of $5,000 or more and a useful life of one or more years).

*Participant/Trainee Support Costs:* Provide a detailed explanation and a table of the number and types of students (e.g., pre-doctoral, doctoral, post-doctoral) receiving Tuition/Fees/Health Insurance, Stipends, Travel and Subsistence. Refer to Guidance Appendix C for Guidelines for Fellows/Trainees.

*Supplies:* List the items that the project will use. In this category, separate office supplies from medical and educational purchases. Office supplies could include paper, pencils, and the like; medical supplies are syringes, blood tubes, plastic gloves, etc., and educational

supplies may be pamphlets and educational videotapes. Remember, they must be listed separately.

*Consultant Costs:* Give name and institutional affiliation, qualifications of each consultant, if known, and indicate the nature and extent of the consultant service to be performed. Include expected rate of compensation and total fees, travel, per diem, or other related costs for each consultant.

*Subawards/Consortium/Contractual Costs:* Applicants and/or awardees are responsible for ensuring that their organization and/or institution has in place an established and adequate procurement system with fully developed written procedures for awarding and monitoring all contracts. Applicants must provide a clear explanation as to the purpose of each contract, how the costs were estimated, and the specific contract deliverables. Grantees must notify potential subrecipients that entities receiving subawards must provide the grantee with their DUNS number.

*Other:* Put all costs that do not fit into any other category into this category and provide an explanation of each cost in this category. In some cases, rent, utilities and insurance fall under this category if they are not included in an approved indirect cost rate.

Applicants may include the cost of access accommodations as part of their project's budget, including sign interpreters, plain language and health literate print materials in alternate formats (including Braille, large print, etc.); and cultural/linguistic competence modifications such as use of cultural brokers, translation or interpretation services at meetings, clinical encounters, and conferences, etc.

*Indirect Costs:* Indirect costs are those costs incurred for common or joint objectives which cannot be readily identified but are necessary to the operations of the organization, e.g., the cost of operating and maintaining facilities, depreciation, and administrative salaries. For institutions subject to OMB Circular A-21, the term "facilities and administration" is used to denote indirect costs. If an organization applying for an assistance award does not have an indirect cost rate, the applicant may wish to obtain one through HHS's Division of Cost Allocation (DCA). Visit DCA's website at: http://rates.psc.gov/ to learn more about rate agreements, the process for applying for them, and the regional offices which negotiate them.

Indirect costs under training grants to organizations other than state, local or Indian tribal governments will be budgeted and reimbursed at 8% of modified total direct costs rather than on the basis of a negotiated cost agreement, and are not subject to upward or downward adjustment. Direct cost amounts for equipment (capital expenditures), tuition and fees, and subgrants and contracts in excess of $25,000 are excluded from the actual direct cost base for purposes of this calculation.

**v. *Staffing Plan and Personnel Requirements***

Applicants must present a staffing plan and provide a justification for the plan that includes education and experience qualifications and rationale for the amount of time being requested for each staff position. Position descriptions, including the project director, that identify the roles, responsibilities, and qualifications of proposed project staff must be included in **Attachment 5.** When applicable, biographical sketches should include training, language fluency and experience

working with the cultural and linguistically diverse populations that are served by their programs.

**Biographical Sketch Instructions**

Provide a biographical sketch for senior key professionals contributing to the project. The information must be current, indicating the position which the individual fills and including sufficient detail to assess the individual's qualifications for the position as specified in the program announcement and position description. Each biographical sketch must be limited to one (1) page or less, including recent selected publications. Include all degrees and certificates. When listing publications under Professional Experience, list authors in the same order as they appear on the paper, the full title of the article, and the complete reference as it is usually cited in a journal. The sketches should be arranged in alphabetical order, after the project director's sketch and attached to SF 424 Senior/Key Person profile form. The biographical sketch must include:

**Name** (Last, first, middle initial),
**Title on Training Grant,**
**Education,** and,
**Professional Experience**, beginning with the current position, then in reverse chronological order, a list of relevant previous employment and experience. Also, a list, in reverse chronological order, of relevant publications, or most representative, must be provided. Please provide information on one (1) page or less.

**vi.** ***Assurances***

Complete Application Form SF-424B Assurances – Non-Construction Programs provided with the application package.

**vii.** ***Certifications***

Use the Certifications and Disclosure of Lobbying Activities Application Form provided with the application package. Any organization or individual that is indebted to the United States, and has a judgment lien filed against it for a debt to the United States, is ineligible to receive a federal grant. By signing the SF-424 R&R, the applicant is certifying that they are not delinquent on federal debt in accordance with OMB Circular A-129. (Examples of relevant debt include delinquent payroll or other taxes, audit disallowances, guaranteed and direct student loans, benefits that were overpaid, etc.). If an applicant is delinquent on federal debt, they should attach an explanation that includes proof that satisfactory arrangements have been made with the Agency to which the debt is owed. This explanation should be uploaded as Attachment 7.

**viii.** ***Project Abstract***

Provide a summary of the application. Because the abstract is often distributed to provide information to the public and Congress, please prepare this so that it is clear, accurate, concise, and without reference to other parts of the application. It must include a brief description of the proposed project including the needs to be addressed, the proposed services, and the population group(s) to be served.

Please place the following at the top of the abstract:

- Project Title
- Applicant Organization Name
- Address
- Project Director Name
- Contact Phone Numbers (Voice, Fax)
- E-Mail Address
- Web Site Address, if applicable

Abstract content:

PROBLEM: Briefly (in one or two paragraphs) state the principal needs and problems which are addressed by the project.

GOAL(S) AND OBJECTIVES: Identify the major goal(s) and objectives for the project period. Typically, the goal is stated in a sentence or paragraph, and the objectives are presented in a numbered list. Objectives must be time-framed and measurable.

METHODOLOGY: Describe the programs and activities used to attain the objectives and comment on innovation, cost, and other characteristics of the methodology. This section is usually several paragraphs long and describes the activities which have been proposed or are being implemented to achieve the stated objectives. Lists with numbered items are sometimes used in this section as well.

HP 2020 OBJECTIVES: List the primary Healthy People 2020 goal(s) that the project will address. Healthy People 2020 goals can be found online at http://www.healthypeople.gov/2020/topicsobjectives2020/default.aspx.

COORDINATION: Describe the coordination planned with appropriate national, regional, state and/or local health agencies and/or organizations in the area(s) served by the project.

EVALUATION: Briefly describe the evaluation methods used to assess program outcomes and the effectiveness and efficiency of the project in attaining goals and objectives. As appropriate, list training program specific targets in addition to any of the specific program measures they intend to use.

ANNOTATION: Provide a three- to - five-sentence description of your project that identifies the project's purpose, the needs and problems, which are addressed, the goals and objectives of the project, the activities, which will be used to attain the goals and the materials which will be developed.

The project abstract must be single-spaced and limited to one page in length.

**ix.** ***Project Narrative***

This section provides a comprehensive framework and description of all aspects of the proposed program. It must be succinct, self-explanatory, and organized by the following sections in order for reviewers to understand the proposed project. Use the following section headers for the Project Narrative:

## A. PURPOSE/NEED

This section should address the following two questions:

1) What is the need for this training project?
2) How will your project fill this need?

Briefly describe the specific needs in adolescent health issues and leadership training that the training program proposal aims to address, citing needs assessment data and/or national, regional, state and local demand, as applicable. State concisely how the proposed project will uniquely address the identified needs and how these efforts relate to the stated purpose of the grant program announcement as described above.

## B. METHODOLOGY/RESPONSE

An overview of the structure of the Methodology/Response is outlined below. The Methodology/Response will be divided into seven sections:

1) Goals and Objectives
2) Long-term Trainees, including discussion on the characteristics of the trainees and recruitment methods
3) Design of the training program, specifically focusing on how the program addresses leadership; public health, Title V, and related legislation; clinical preparation, research, communication and teaching; and MCH curriculum. MCH curriculum must include discussion of such content as life course, interdisciplinary training and practice, diversity, cultural and linguistic competence, family/adolescent-centered care, emerging issues, technology, and innovation.
4) Settings
5) Populations served, including underserved populations
6) Coordination with other MCH training programs, State Title V agencies, and other partners, such as juvenile justice, housing, education including school-based health programs, and community service and health centers.
7) Addressing the MCH Training Strategic Plan

Each section is further described in detail.

### 1) Goals and Objectives

State the overall goal(s) of the project and list the specific objectives that respond to the stated need/purpose for this project. The objectives must be **measurable** with specific **outcomes** for each project year which are attainable in the stated **time frame**. These outcomes are the criteria for evaluation of the program.

Describe, by year, the activities, methods, and techniques to be used to accomplish the objectives of the project. Describe the roles and responsibilities of key project personnel. Provide a timetable and identify responsible persons for implementation of the activities that will support the objectives.

## 2) Long-Term Trainees

The purpose of the LEAH program is to improve the health of adolescents by preparing trainees from a wide variety of professional disciplines to assume leadership roles and to ensure high levels of interdisciplinary clinical competence. Besides providing MCH leadership training in adolescent health, LEAH projects as part of the experiential curricula are expected provide health care services to their adolescent populations.

The application must include criteria for and a description of methods of trainee recruitment and selection of trainees whose career goals are consonant with the program objectives, including an interest in acquiring knowledge and skills to evaluate, diagnose or rule out, develop, and provide evidence-based interventions to adolescents in an interdisciplinary, adolescent-centered/family-involved, and culturally competent manner.

Recruitment of qualified trainees who are culturally, racially and ethnically diverse is a priority for the MCH Training Program. Applicants must describe their previous success in recruiting culturally, racially and ethnically diverse trainees. The MCH Training Program focuses on recruiting culturally, racially and ethnically diverse trainees because studies have documented that diverse providers are more likely to serve underserved populations, thus increasing the likelihood that health care disparities will be addressed.

The applicant must describe the plan for encouraging recruitment of trainees from culturally, racially, and ethnically diverse backgrounds and for evaluating the success of the recruitment efforts. Training projects are encouraged to develop innovative means of recruiting students from underrepresented groups at the high school, community college, and undergraduate levels. Performance Measure #9 requires annual reporting on the percentage of trainees from underrepresented racial and ethnic groups. See Appendix A for the performance measures and administrative data required for this program.

There must also be a plan for tracking and reporting on the field leadership of former trainees. This plan must include longitudinal follow-up data about graduates' employment, research, advocacy efforts, programs initiated, publications submitted, etc. These data will be reported on Performance Measure #8

Please not that fellowships refer to non-degree-related training and traineeships refer to degree-related training. As used elsewhere the term "trainee" is generic. Trainee support varies by discipline in accordance with standards of the profession, availability of other support, nature of training required to meet program goals, and other factors. Appendix B, Trainee/Fellow Guidelines, defines trainees and fellows and provides guidelines for support.

To be considered a long-term trainee, the trainee must have completed 300 hours or more of LEAH leadership and didactic training, in addition to LEAH field work and clinical training requirements. The following outline is intended as a guide for the types of trainees/fellows generally supportable in each profession and consonant with core faculty requirements:

1) Pediatrics, internal medicine, family medicine – post-residency fellowships in adolescent medicine of three years' duration for pediatrics and a minimum of two years duration for internal medicine and a minimum of two years duration for family medicine. LEAH Programs should review the Accreditation Council for Graduate Medical Education

(ACGME) guidelines, effective 07/01/2007, for fellowship education in adolescent medicine in order to ensure appropriate training for medicine fellows. Please visit http://www.acgme.org/acWebsite/RRC_320/320_prIndex.asp to view the ACGME program requirements.

2) Nursing – traineeships for master's or doctoral candidates. Consideration may be given to some post-master's or post-doctoral fellowships.

3) Social Work – traineeships for master's or doctoral candidates. Consideration may be given to doctoral candidates in a clinical sequence, and to clinical fellowships.

4) Nutrition – traineeships for master's or doctoral candidates. Consideration may be given to some post-master's or post-doctoral clinical fellowships.

5) Psychology – post-doctoral fellowships.

**Conditions of Support.** Trainees must be:

1) At least a master's candidate;
2) **long term (minimum of 300 hours)**; and
3) enrolled in programs providing a minimum of 50% of the total training experience for which support is requested as a part of the clinical program, or in programs directly under the control and supervision of training faculty.

Applicants must provide evidence of the productivity of the training program in terms of the number of trainees in various disciplines who have completed the training program in adolescent health and their current professional activities. Support for trainees is limited to those whose career goals include leadership in the field of adolescent health. Trainees may be supported in each of the professions represented on the core faculty (medicine, nursing, nutrition, psychology, and social work). Trainees from other relevant disciplines may also be supported with permission from MCHB. Since the intent of the LEAH program is to promote an interdisciplinary health professions team model of care provision for adolescents, sufficient numbers of students from the appropriate variety of disciplines indicated are necessary both to learn and practice these principles.

**Other Trainees.** Faculty time not required for meeting the primary training mission, as described above, may be applied to other types of training which are related to the basic goals of the LEAH program. LEAH projects are expected to develop exemplary models of education and training that may include, for example, elective experiences for short-term and medium-term trainees not supported by the training grant, such as medical students and residents, nurse practitioner students, pediatric dentists, lawyers and other participating health care professionals.

Short-term trainees are defined as trainees receiving less than 40 contact hours in a program. Continuing Education students should not be in this category.

Medium-term trainees are defined as trainees receiving equal to or more than 40 and less than 300 contact hours in a program. Fellows and long-term trainees are expected to participate in these teaching activities, and to serve as role models for students, residents, and other short-term and medium-term trainees. MCHB has refined the definition of Medium Term Trainees as those

who have completed either 40-149 hours or 150-299 hours of training. This is reflected in Appendix B in the attached "MCH Training and Education Programs Data Form."

### 3) Design of the Training Program

Maternal and Child Health Bureau support of LEAH programs is justified primarily on the basis of training health professional personnel in an interdisciplinary manner and setting for leadership roles in adolescent health. LEAH programs are expected to demonstrate leadership development in the five core disciplines of medicine, nursing, nutrition, psychology and social work, but are not limited to these five disciplines. The training program design, competencies, and curriculum must prepare interdisciplinary health professionals for the full range of adolescent health issues, and the new leadership roles they will play in the emerging health care system for adolescents.

If adolescents are to be well-served in the emerging health care system with a greater emphasis on primary care and preventive services, competent leadership is needed in the disciplines specified. Educational programs must prepare professionals to: provide and ensure high-quality, cost-effective, community-based, integrated services; work in primary care settings; work in true partnership with adolescents and their families; respond to the growing diversity of the population; manage information effectively; work across systems (State Title V, education, social services, and other partners) toward integration of care; contribute to policy discussions; and address ethical and legal issues. The curriculum must train leaders to cultivate interdisciplinary practice and research in new settings, including those which emphasize primary care or uni-disciplinary or multidisciplinary methods.

Programs are encouraged to use innovative approaches to professional education and patient care, to integrate bio-behavioral, bio-psychological and environmental health concepts and practices into the curriculum and to demonstrate leadership in improving services for adolescents. Training must balance biological, developmental, mental health, social, economic, and environmental issues. Training also must foster development of leadership attributes and a broad public health perspective.

Programs must develop a core curriculum which includes significant clinical and other practical experiences and didactic content on a broad array of topics relevant to all aspects of adolescent physical (including oral health) health, mental health, and social/behavioral issues. Educational objectives must incorporate the acquisition of knowledge of biological, psychological and social adaptation; growth and development; primary, secondary and tertiary aspects of disease prevention; and health promotion among adolescents, including those with special health care needs. The curriculum must address strategies that strengthen youth involvement to become successful adults, exercise responsible reproductive health, and achieve gender-specific empowerment.

#### a. Leadership

The MCH Training Programs place a particular emphasis on leadership education. The curriculum and education training must include content and experiences to foster development of effective leadership competencies. Leadership training prepares MCH health care professionals to move beyond excellent clinical or health administration practice to leadership, through practice, research, teaching, administration, and advocacy.

*Maternal and Child Health Leadership Competencies, Version 3.0* was published in November 2009. As articulated by the MCH Leadership Competencies Workgroup, "An MCH leader inspires and brings people together to achieve sustainable results to improve the lives of the MCH population."[7]

A more extensive definition was also provided in the document. "An MCH leader is one who understands and supports MCH values, mission, and goals[8] with a sense of purpose and moral commitment. He or she values interdisciplinary collaboration and diversity and brings the capacity to think critically about MCH issues at both the population and individual levels, as well as to communicate and work with others and use self-reflection. The MCH leader possesses core knowledge of MCH populations and their needs and demonstrates professionalism in attitudes and working habits. He or she continually seeks new knowledge and improvement of abilities and skills central to effective, evidence-based leadership. The MCH leader is also committed to sustaining an infrastructure to recruit, train and mentor future MCH leaders to ensure the health and well-being of tomorrow's children and families. Finally, the MCH leader is responsive to the changing political, social, scientific, and demographic context and demonstrates the capability to change quickly and adapt in the face of emerging challenges and opportunities."

Graduates of MCH Leadership training programs improve the system of care for women (including women of reproductive age), mothers, children, youth and adolescents. The goal of leadership training is to prepare public health trainees who have shown evidence of leadership attributes and who have the potential for further growth and development as leaders. In order to accomplish this goal, trainees must achieve and excel in a variety of competencies. A complete description of the competencies, including definitions, knowledge areas, and basic and advanced skills for that competence is included at http://leadership.mchtraining.net. Clearly describe how these MCH Leadership Competencies will be directly cultivated by the training curriculum.

Identify the competencies expected of the graduates and the required curriculum, including didactic and experiential components. A brief syllabus, including descriptions of courses, workshops, seminars, and experiences should be included in the Appendix of the application.

**b. Public Health, Title V, and Related Legislation**

The program and its curriculum must address a broad public health perspective. It must emphasize, either as discrete topics or as topics integrated in other components, appropriate didactic and experiential content relative to MCH/Title V and related legislation, such as Title X (Family Planning), XIX (Medicaid/EPSDT), and XXI (State Children's Health Insurance Program). The educational curricula, in addition to promoting excellence in scholarship and leadership, must emphasize the integration of services supported by states (including Title V), local agencies, organizations, private providers, and communities. Influences on the health status of children such as their families, the environment, and cultural values, economic, legal and political conditions, are vital components of leadership training in an MCH curriculum.

The program and its curriculum will also emphasize the development, implementation and evaluation of systems of adolescent health care. At a minimum, a broad public health

[7] Adapted from: George, B. (2006, October 30). Truly authentic leadership. *U.S. News & World Report*, 52.

[8] Maternal and Child Health Bureau (MCHB). *Strategic Plan, FY 2003–2007*. Retrieved February 20, 2007, from MCHB Web site: http://www.mchb.hrsa.gov/about/stratplan03-07.htm#1.

perspective includes, but is not limited to: community needs assessment, advocacy, public policy formulation and implementation, legislation/rule making, financing, budgeting, program administration, consultation, and program planning and evaluation.

The curriculum must also emphasize content relating to: science-based judgment, evidenced-based practice and documentation of quality outcomes and performance within an established plan of care; expansion of the direct service roles to include consultation, and collaboration and supervision; and, various service delivery models and approaches. The curriculum must also address emerging public health issues relevant to adolescent health.

The program must provide opportunities for trainees to interact with MCH personnel, including State Adolescent Health Coordinators, and other public health professionals. Program faculty must provide consultation and technical assistance to develop or improve community-based services, and such technical assistance will be utilized to enhance trainee exposure to and understanding of such services.

Programs must document active and effective relationships with State Title V MCH Programs and other related programs, e.g., Title X, Title XIX, including consultation, in-service education, and continuing education geared to the needs of several states or a HRSA region. Collaboration with agencies or programs providing educational, legal, social, recreational, rehabilitative or similar services; or service on boards, commissions, advisory groups or similar entities which set standards, help define public policy or otherwise influence service on a state, regional or national basis will also be documented.

In addition to the students' exposure to public health and Title V, LEAH faculty must engage fellows and trainees in providing technical assistance to such agencies in the development of new adolescent health programs and in the application of innovative techniques affecting the health care system. Collaboration/ technical assistance with State Adolescent Health Coordinators is a priority. Collaboration must be documented in the application, i.e., descriptions of committees, copies of agreements/contracts, etc.

**c. Clinical Preparation**

Training must include those clinical and non-clinical elements and components specified below. The project plan must describe the patient population, diagnostic categories and services, and the various functions related to the provision of such services. The plan should include a description of trainee roles in provision of clinical services, extensiveness of clinical preparation, and clinical supervision.

Training must be structured on exemplary, comprehensive, interdisciplinary service models in a variety of institutional and community-based settings with a client population representative of the cultural, linguistic, social and ethnic diversity of the community. Programs must identify a mechanism to receive input from adolescents and families who utilize adolescent health services. Programs must provide clinical services for adolescents that are interdisciplinary and involve families and youth, as appropriate. Services should include health promotion, disease prevention and care coordination, as well as diagnosis and treatment of conditions that range from simple to highly complex.

Training must occur within clinical settings and under the direction of the funded program, if possible, and in community-based settings with client populations representative of the cultural, social and ethnic diversity of the community. Focus must be on prevention, early detection, assessment, care coordination, and treatment. Programs must involve their trainees in a variety of settings that help to foster achievement of community-based, coordinated care. Sites should include out-patient and in-patient programs in tertiary care centers, as well as community-based sites that are off-campus from the academic medical center. Examples include community and migrant health centers (Federally Qualified Health Centers) supported by HRSA's Bureau of Primary Health Care, free clinics, school-based health centers, college health services, sports medicine programs, clinical services for detained and incarcerated youth, clinical services for adolescents in the foster care system and in residential programs, psychiatric and substance abuse treatment programs for adolescents and programs for HIV infected youth. The medical home model should also be promoted. All trainees should have applied field experiences in such settings.

**d. Research**

Applicants must document research and other scholarly activities of faculty and students relating to LEAH, and must define the relevance of these activities to the training program. Each student is expected to engage in one or more active research projects during his/her tenure, and to seek to disseminate findings at scientific symposia, through published articles in peer reviewed journals and to practitioners and policymakers.

Master's level students are expected to gain knowledge and skills in research methodology and dissemination of research findings into practice. Doctoral and post-doctoral students are to prepare and present findings in peer reviewed journals and meetings. Programs must provide for the conduct of collaborative research by the faculty and by trainees under their supervision, e.g., contributing new knowledge, validating effective intervention strategies, assessing quality, or linking intervention to functional outcomes and quality of life.

**e. Communication and Teaching**

All students are expected to achieve effective clinical communication and teaching skills, as well as presentation skills appropriate for a variety of professional and community audiences. Training must provide trainees with the opportunities to practice, demonstrate, and document effective teaching and communication for and with diverse constituencies (e.g., professional peers; parents; public health leaders; etc). These experiences should incorporate multiple forms of communication and diverse venues and methods of delivery. In addition, long-term doctoral and postdoctoral trainees are expected to advance administrative skills through assigned administrative responsibility for at least one focused service or teaching activity.

Although the primary purpose of MCHB support for training in a LEAH program is the long-term training of health professionals for leadership roles, each program should demonstrate communication and teaching in action by conducting a minimum of one continuing education activity per year for the provider community to enhance skills or disseminate new information. Such programs must target health and related care providers and should be based on specific needs identified interactively with the group(s) to be served. The plan for the conduct of such continuing education activities should be defined in the project narrative.

Programs must provide for periodic meetings/workshops/conferences for the purpose of furthering the development of adolescent health and related services at the national level. It is expected that the LEAH programs will both coordinate their individual efforts and collaborate in the development of mutual projects of significance to the MCH community. In addition continuing education for those professionals working in adolescent health continues to be an important aspect of LEAH projects. Applicants are expected to develop, implement, and track LEAH project continuing education efforts. The plan for the conduct of such outreach activities must be defined in the project narrative.

**f. MCH Curriculum**

Content and philosophy must be geared to preparation of graduates to assume leadership roles in the development, improvement and integration of systems of care in programs providing adolescent health services in community-based, adolescent-centered/family-involved settings.

Programs must have an MCH focus with an emphasis on preventive, diagnostic, treatment/management and follow-up for adolescent health. By focusing on the importance of health promotion, disease prevention, and the benefits of coordinated health care, families, practitioners, researchers, and educators can develop creative approaches for improving the health of mothers, children and families, particularly those vulnerable groups whose needs are not currently being met by systems of care. Curricula must include training in and about community-based programs and public health services that provide leadership opportunities in interdisciplinary, adolescent -centered, comprehensive, and coordinated care. Attention to the needs of adolescents living in underserved communities is strongly encouraged.

The curriculum must clearly define how the training program incorporates the following content to assure an adequate base of knowledge and experience. Programs must develop clear, measurable educational objectives for an interdisciplinary core curriculum, clinical and didactic, which incorporate the acquisition of knowledge of:

- all aspects of adolescent health;
- the social environment—the family, community, school;
- life course and social determinants of health;
- interdisciplinary team skills (e.g., team building, shared leadership, mutual accountability);
- diversity;
- cultural and linguistic competence;
- adolescent-centered/family-involved services;
- emerging issues;
- technology; and
- innovation.

These parts of the curriculum are defined in more detail below:

**Life Course Framework:** In alignment with MCHB's concept paper and plans to focus on life course, the LEAH curriculum will address health promotion issues for adolescents by implementing a curriculum that emphasizes adolescent and youth development within the life course development and socio-ecological framework. This framework emphasizes the cumulative impact of adolescents developing within families, families existing within a

community, and the community embedding within the larger society. The curriculum will prepare trainees to understand how systems interact with and influence each other to either decrease or increase risk factors or protective factors that affect a range of health and social outcomes for adolescents. MCHB's Training Program is cultivating this comprehensive, evidence-based framework into curricula, programs, and policies, assuring that health professionals trained in interdisciplinary settings address the needs of adolescents.

**Interdisciplinary Training and Practice:** Central to the LEAH Training Program is the interdisciplinary nature of the program. This requires that there be a core of clinical and didactic curricula and experiences which bring together all faculty and long-term trainees, in such a manner and for such periods of time as are necessary, for the interdisciplinary process to be effectively demonstrated, developed, and practiced.

Interdisciplinary practice is a team approach among professionals, consumers, and community partners, applied in the organization and delivery of health services, training, policy, and research. This approach includes:

- A supportive environment which values and utilizes the skills and expertise of each team member to arrive at outcome-driven joint decisions;
- Mutual respect among disciplines; and
- Shared leadership, incorporating accountability and responsibility for outcomes.

Curricula descriptions must clearly demonstrate how interdisciplinary training and practice will be accomplished.

**Diversity in MCH Training:** LEAH training must also include content and experiences to prepare professionals to provide leadership in continued cultivation of a diverse MCH workforce. MCHB strives to develop an MCH workforce that is more reflective of the diversity of the nation. This strategy requires methods to increase the diversity of MCH faculty and students.

By addressing faculty and trainee diversity, and incorporating cultural competence and adolescent-centered/family-involved care into training programs, the MCHTP aims to improve the quality of care for the MCH population. Over time, the MCHTP must evaluate whether the emphases on diversity, cultural competence and family centered care might also help to reduce health disparities. For more information on MCHTP diversity activities, particularly the Diversity Peer Learning Collaborative, go to http://www.mchb.hrsa.gov/training/grantee_resources_dtpc.asp.

**Cultural and Linguistic Competence:** Cultural competence is defined as the knowledge, interpersonal skills and behaviors that enable a system, organization, program, or individual to work effectively cross culturally by understanding, appreciating, honoring, and respecting cultural differences and similarities within and between cultures. Cultural competence is a dynamic, ongoing, developmental process that requires a long-term commitment and is achieved over time.

The curriculum must include content about the differing social, cultural, and health practices of various racial, ethnic, and economic groups, and the implications of these relative to health status and provision of health care. Training must be structured on a broad range of exemplary, interdisciplinary, comprehensive services that provide adolescent/family-centered, coordinated

care that is responsive to the cultural, social, linguistic, and ethnic diversity of the community. For additional resources and information, applicants are encouraged to refer to the National Center for Cultural Competence at http://gucchd.georgetown.edu/67212.html.

The applicant must demonstrate how the training program will address issues of cultural competence, such as including cultural competence training in the curriculum, administrative procedures, faculty and staff development, and recruiting culturally, racially and ethnically diverse faculty and students. Training must be structured on a broad range of exemplary, interdisciplinary, comprehensive services which provide adolescent/family-centered, coordinated care that is responsive to the cultural, social, linguistic, and ethnic diversity of the community.

For more information about cultural competence, please visit http://www.mchb.hrsa.gov/training/goal_workforce_diversity.asp.

For more information about the Curricula Enhancement Module Series created by the National Center for Cultural Competence, please visit http://www.nccccurricula.info/.

Besides teaching concepts of cultural and linguistic competence, the Bureau's intent is to ensure that project interventions are responsive to the cultural and linguistic needs of special populations, that services are accessible to consumers, and that the broadest possible representation of culturally distinct and historically under-represented groups is supported through programs and projects sponsored by MCHB. In order to assure access and cultural competence, it is expected that projects will involve individuals from populations to be served in the planning and implementation of the project.

**Adolescent-Centered/Family-Involved Care:** The curriculum must include content about adolescent-centered/family-involved care that assures the health, safety and well-being of adolescents and their families through the development of a respectful partnership. It honors the strengths, cultures, traditions and expertise that everyone brings to this relationship. Adolescence is a time of growth toward adulthood, and health care and care coordination need to acknowledge the universal adolescent developmental task of independence. The principles and practice of confidentiality are an important component of the curriculum. In addition, not all adolescents can involve their families in decision-making and trainees need to learn how to constructively assist and support adolescents, their families, and other concerned adults through sensitive and difficult sets of circumstances.

The foundation of adolescent-centered/family-involved care is the partnership among adolescents, families and professionals. Key to this partnership are the following principles:

- Adolescents, their families and professionals work together in the best interest of the adolescent. The adolescent learns how to assume a partnership role.
- Everyone respects the skills and expertise brought to the partnership.
- Communication and information sharing are open and objective. (Note that this is an ideal principle that should always be followed between the professional and the adolescent but may not always be possible to follow based on the existing relationship between an adolescent and his/her family and the specific set of circumstances. The curriculum needs to address how trainees can help families and adolescents work toward this ideal and recognize when other communication strategies need to be employed.)

- Participants make decisions together, if possible, with the adolescent gaining greater autonomy and independence in decision-making as a part of normal development.
- There is a willingness to negotiate.

Based on the principles of the three-way partnership among a health care professional, an adolescent, and his/her family, this care:

1) Supports youth as they transition to adulthood and respects their growing independence.
2) Supports adolescents in learning about and participating in their health care and decision-making, and strengthens their health literacy skills.
3) Acknowledges the family as the involved constant in an adolescent's life.
4) Builds on family strengths.
5) Honors cultural diversity and family traditions.
6) Encourages family-to-family and adolescent peer support.
7) Recognizes the importance of community-based services.
8) Promotes a developmental approach that is tailored to each adolescent's needs.
9) Develops policies, practices, and systems that are adolescent-friendly.

**Emerging Issues:** The curriculum must reflect awareness of emerging health problems and practice issues, such as those outlined in *Healthy People 2020 National Health Promotion and Disease Prevention Objectives, Bright Futures Guidelines for Health Supervision of Infants, Children and Adolescents* and recent Institute of Medicine (IOM) reports. Of particular note are the Healthy People 2020 objectives specific to adolescent health. These objectives represent the most serious health and safety issues facing this population including mortality, unintentional injury, violence, substance use and mental health, reproductive health, and prevention of adult chronic diseases. Rather than utilizing approaches that solely focus on preventing negative health outcomes in adolescents, programs should consider implementing approaches that advance positive youth development, which emphasizes building skills and assets in youth in addition to disease prevention. Emerging public health issues include health disparities and changing demographics.

The Home Visiting provisions under the Affordable Care Act (ACA) may provide opportunities for LEAHs to collaborate with home visiting programs. Additionally, expansion of community health centers under ACA may provide new training sites and other experiences for trainees.

**Technology:** The curriculum shall incorporate the use of web-based technology for communication and information acquisition and processing, including distance learning modalities for lifelong learning, and continuing education. Programs will use principles of adult learning and effective education models utilizing available technologies such as e-learning systems, course management software, web-based conferencing, social media and social networking tools.

**Innovation:** MCH Training program must include training content and experiences, as well as trainee and faculty practice that contribute to the accomplishment of the objectives listed above. MCH funded training programs play a vital role in the development of new knowledge and the promotion of innovation in practice, research and policy. The applicant must clearly describe how the curricula and trainee experiences within the program assure trainees are equipped to practice, respond and lead utilizing multiple sources of information and can synthesize, recognize and contribute to the MCH science and related practice. Program experiences must be

designed to implement new and emerging technologies in clinical practice and assure trainees have access to and can practice utilizing these technologies in their respective fields.

**4) Settings**

It is expected that the clinical component of the training will occur both within the primary program setting and in diverse community settings. The primary setting must provide sufficient and appropriate spaces for core faculty and student offices and for clinical and teaching activities. The training plan and settings must be structured to assure sufficient formal interaction and informal association amongst trainees and faculty across disciplines to accomplish and enhance the interdisciplinary process and practice on which the program is based. Applicants are encouraged to coordinate clinical training opportunities with MCHB-funded research sites and Title V programs.

Practicum sites must provide exemplary, comprehensive, community-based services in a variety of institutional and rural/urban community-based settings focused on adolescents of the cultural, social, and ethnic diversity of the community. Practicum sites in underserved communities are especially recommended.

**5) Populations Served**

In particular, MCHB places special emphasis on improving service delivery to women, children, adolescents, and families from communities with limited access to comprehensive care. This same special emphasis applies to improving service delivery to adolescents, with special emphasis on youth with special health care needs and youth living in rural areas.

Applicants are strongly encouraged to work collaboratively with State Title V agencies and other MCH training programs to maximize access to MCH services, with special emphasis on underserved and at-risk adolescents.

Programs will demonstrate how their programs are serving a state, region, or geographic area that is not served by a LEAH training program and outreach efforts. Further, if applicable, the applicant should describe how they are meeting a need in their geographic area in terms of training needed health professionals to screen, diagnose, or serve adolescents.

**6) Coordination with Other MCH Training Programs, State Title V Agencies, and Other Partners**

All LEAH applicants are encouraged to coordinate activities and collaborate with other supported MCHB training and research programs, Title V Programs, and community partners. Discuss the collaboration for your LEAH program, outlining in detail relationships with such partners as juvenile justice, housing, education including school-based health programs, area community education centers, community service and community based health centers, among others. Describe involvement with the National Initiative on Adolescent Health.

Applicants will describe:

- existing partnerships or new partnerships with service systems already serving MCH populations, including but not limited to state and local Title V programs; home visiting programs; and local organizations impacting maternal and child health;

- coordination with other federal agencies or programs addressing MCH issues including, but not limited to other HRSA programs, community-based health centers; Area Health Education Centers, etc.
- collaborations/partnerships with MCHB training and research investments. There must be a clear explanation of how the training program coordinates with and supports the collaborative impact of MCH training investments.
- Other partners, such as juvenile justice, housing, education including school-based health programs, community service centers, among others.

A map of current MCHB LEAH training investments is included in Appendix D, and a map of current investments is at http://www.mchb.hrsa.gov/training.

As a part of collaboration, technical assistance to partners and stakeholders is expected of LEAH projects. Technical Assistance/collaboration is defined as mutual problem solving and collaboration on a range of issues, which may include program development, clinical services, program evaluation, and policy & guidelines formulation. Collaborative partners might include state or local health agencies, and education or social service agencies. Faculty often serve on advisory boards to develop &/or review policies at the local, state, or national levels. Applicants must discuss current and planned technical assistance efforts.

**7) Addressing the MCH Training Strategic Plan**

As outlined in Section I.2, Background of this funding opportunity announcement, MCHTP is in the process of revising its strategic plan for 2012-2020, which should be finalized in 2012. Throughout the Methodology and Response section, applicants have addressed many of the goals and objectives of the strategic plan. In this section, address any goals that have NOT been addressed in Sections 1-6. This provides the applicant the opportunity to highlight other unique activities or strategies used in the project that address the MCH Training Strategic Plan.

Below are outlined the MCH Training Strategic plan draft goals and instructions. This narrative must augment, not repeat, what has been described in Sections 1-6.

**Goal 1: Engage, develop, and support accountable MCH leaders.**
Describe how the training program will engage, develop and support MCH leaders utilizing the MCH Leadership competencies framework; assess trainees and faculty on the MCH leadership competencies; recruit diverse emerging trainee leaders; and, assure teaching and clinical preparation of MCH leaders.

**Goal 2: Generate, translate, and integrate new knowledge, emerging technologies and promising strategies into innovations in MCH training, policy and practice.**
Describe project plans around training for innovation and systems change, MCH curricula and emerging issues, and incorporation of and training on technology to promote impact of MCH training.

**Goal 3: Prepare and empower MCH leaders to promote health equity, wellness, and reduce disparities in health and healthcare.**
Describe project plans around promotion of: diversity in MCH training and geographic representation; cultural and linguistic competence; addressing health disparities; and, wellness.

**Goal 4: Increase outreach, visibility, and utilization of the expertise and products of the MCH community.**
Describe project plans around the use of innovative technology to assure widespread dissemination of MCH knowledge and products; and MCH network development, including faculty, trainees and alumni.

**Goal 5: Promote the health of MCH populations through collaboration, where MCH professionals strategically engage and invest in Title V programs and stakeholders to promote the health of MCH populations through science and service.**
Describe project plans to develop and demonstrate strategic collaboration skills and investment; and, assure coordination with other MCH investments, initiatives and activities.

**Goal 6: Promote systems of ongoing assessment and continuous improvement that demonstrate the value (quality, efficiency, and outcomes) of MCH professional development in shaping professionals who are well equipped to enhance the health of the population over the life course.**
Describe project plans to address ensuring and improving measurement for MCH; assessing impact of MCH professional development and methods; actionable assessments and using data for program improvement; research experience and products.

## C. RESOURCES/CAPABILITIES

Describe briefly the administrative and organizational structure within which the program will function, including relationships with other departments, institutions, organizations or agencies relevant to the program. Charts outlining these relationships must be included in **Attachment 3** and described in the narrative.

Describe briefly the physical setting(s) in which the program will take place, including the planned location and time of LEAH training activities. Provide an explanation as to how the location and time were determined and demonstrate participation across multiple disciplines.

Include a brief, specific description of the available resources (faculty, staff, space, equipment, clinical facilities, etc.), and related community services that are available and will be used to carry out the program. Include biographical sketches of faculty/staff on SF-424 R&R Senior Key Personnel form.

Describe briefly what additional resources are needed to accomplish the stated goals and objectives, i.e., what is requested through project support and why. Position descriptions for key faculty/staff must be included in **Attachment 5**.

Job descriptions should spell out specifically:

- **administrative direction** (from whom it is received and to whom it is provided);
- **functional relationships** (to whom and in what ways the position relates for training and/or service functions, including professional supervision);
- **duties and responsibilities** (what is done and how); and
- **minimum qualifications** (the minimum requirements of education, training, and experience necessary for accomplishment of the job).

Position descriptions should include the qualifications necessary to meet the functional requirements of the position, not the particular capabilities or qualifications of a given individual. A position description should **not exceed 1 page in length**, but can be as short as one (1) paragraph in length due to page limitations.

In keeping with the specialized nature of this program, standards are specified regarding the multiple health professional disciplines which constitute the fundamental core faculty appropriate for MCH support, including their qualifications, responsibilities, and functions. It is not, however, the intent of this funding opportunity announcement to prescribe all details of the faculty arrangements and participants.

**Project Director**

The role of Project Director shall constitute a major professional responsibility and time commitment of the person appointed to the position. The Project Director of a LEAH Program must be a health professional from one of the core LEAH disciplines with demonstrated expertise related to adolescent health. At a minimum, this should include a terminal degree in the director's discipline (e.g., MD, DO, PhD, PsyD). For physicians serving in the role of project director, a board certification in adolescent medicine is required. Project directors from other discipline must provide documentation of specialized training in adolescent health. The Project Director must be the person having direct, functional responsibility for the program for which support is requested. S/he must have demonstrated leadership in adolescent health, expertise and experience in post-graduate level teaching and conduct of scholarly research in adolescent health. **Project Director must commit 30% time/effort, either grant-supported or in combination with in-kind support, to a LEAH Program.** The Project Director has administrative responsibility for the MCH training grant. Deans, department chairs, and others in similar positions may not serve as Project Director or core faculty, or receive payment from project funds, unless special permission from the MCHB Training program is obtained.

**Faculty**

The highly sophisticated nature and complexity associated with interdisciplinary education demands special faculty commitment and dedication. Programs must document appropriately qualified core faculty with adequate time commitment to participate fully in all components of the training program. Programs must have core faculty with demonstrated leadership and appropriate education and experience in adolescent health who represent the disciplines necessary to meet the criteria stated below and the specific goals and objectives included in the project plan. Faculty must include members with experience in community-based service programs that provide population-based care and in integrating adolescent health services into local and state systems of care.

Core faculty must commit adequate time to participate fully in all components of the interdisciplinary training program. Core faculty must include well-qualified professionals from the following core disciplines:

1) pediatrics and/or internal medicine or family medicine,
2) nursing,
3) nutrition,
4) psychology, and
5) social work.

All core faculty must have experience in programs providing health and related services for adolescents and must have significant academic appointments in their discipline in appropriate degree-granting schools or departments of the grantee or an affiliated institution of higher learning. LEAH training programs are expected to demonstrate leadership development in all core disciplines.

In some instances, not all academic disciplines of the core faculty members listed above may be regionally located or proximal to the home institution. If so, flexibility is permitted to the extent that alternative arrangements are academically and educationally acceptable and appropriate, and patient care is acceptable and uncompromised. These arrangements must be clearly specified in the application.

Faculty from other disciplines are strongly encouraged as active participants in the LEAH programs. Prominent examples include the medical specialties and sub-specialties of child and adolescent psychiatry, obstetrics/gynecology, sports medicine, and dermatology; pediatric dentistry; education; law; health education, the social sciences (e.g., anthropology, health economics, sociology); and public health and health administration (e.g., health policy, public and program administration, applied evaluation). LEAH programs are encouraged to establish liaisons with appropriate schools and departments within their parent and neighboring universities and must establish liaisons with other MCHB-supported leadership training programs in their geographic area. (See Appendix D for a map of all currently supported MCHB LEAH Training grants.)

Core faculty must meet at least the minimum standards of education, experience and certification/licensure generally accepted by their respective professions. Each core faculty must demonstrate leadership and must have teaching and clinical experience in adolescent health and in providing health and related services to the adolescent population for which the program is focused. Core faculty must also be able to document cultural competence and knowledge and experience in adolescent-centered/family-involved care or the project must provide appropriate continuing education for faculty to achieve these competencies.

Recruitment of qualified faculty who are culturally, racially and ethnically diverse is a priority for the MCH Training Program. Applicants are requested to discuss university policies and practices, if in place, for recruitments of culturally, racially and ethnically diverse faculty.

Grant support for faculty is to assure dedicated time for meeting the explicit objectives of the training program. Core faculty members have primary responsibility for planning, designing, implementing, supervising, and evaluating all training and service elements. Along with the Project Director, core faculty members should have experience in providing academic, clinical and/or community-based training in adolescent health.

Those faculty who are at an organizational level superior to that of the Project Director, or who are not subject to the Project Director's administrative direction, such as academic deans, department chairs and others in similar positions, while highly valued faculty, may not serve as core faculty, or receive payment from project funds without special approval from the MCHB Project Officer.

Non-MCHB sources of support for core faculty may be used, in whole or in part, so long as such support does not detract from their commitment of time and function to the training program.

**Faculty Responsibilities**
It shall be the responsibility of the appointing academic school or department to determine the basic faculty qualifications, and the responsibility of the employing program to determine and document the additional specialized pediatric training and clinical experience. Core faculty may be functionally, programmatically, or academically responsible to such positions as may be specified in the approved plan and position descriptions, but must be responsible to the LEAH Project Director for the time allocated to the project.

Core faculty members are the chief representatives of their respective professions in the program. As such, they:

- Individually, have primary responsibility for planning, implementing, coordinating, and assuring supervision of all training and service elements of their discipline components, and, collectively, for the interdisciplinary core curriculum of the overall interdisciplinary leadership training program for all trainees;

- Define appropriate criteria for recruitment of trainees of their discipline and jointly select trainees with the appropriate academic school or department and the training director and/or committee;

- Serve as the primary liaison between the program and their professional associates, academic affiliates, clinical departments, and discipline counterparts in state and community programs and provide an adolescent health perspective to trainees in child health across their institution of higher learning;

- Represent their discipline on internal program, policy or governance committees;

- Provide supervision and professional leadership for others of their discipline in the program; and,

- Engage in scholarship directed toward the areas of integrated systems of quality care, capacity building, interdisciplinary training and practice, performance measures, quality assurance and improvement, leadership, policy analysis, medical home, and other important areas established by MCHB.

Functional and program responsibilities must be specified in the narrative and position descriptions.

**Faculty and Staff Support**
Priority must be given to maintenance of the required complement of core faculty as defined herein and as necessary to accomplish project plan objectives. However, to the extent required to meet the primary training mission, including provision of necessary clinical services, additional staffing can be supported. Staff supported through grant funds must be under the administrative direction of the Project Director for all grant-related activities.

**Hosting Annual Meetings**
Programs awarded under this competition will be required to include a plan to develop and convene the LEAH Program meeting during one of the years of the project period in the amount

of $30,000, pending availability of funds. The purpose of this meeting is to promote interchange, disseminate new information, present new research, and enhance national-level, long-term development in MCH adolescent health learning. Responsibilities of the host program include arrangements and payment for the program, speakers, meeting logistics and lodging, plus meeting meals in lieu of one-half the per diem.

Interchange with other programs is required. Each LEAH Program is expected to send two faculty members to the annual grantee meeting. Trainee participation is strongly encouraged. Applicants whose projects are approved and funded will be asked to travel to this program meeting. The time of the meeting will be announced at a later dates.

## D. SUPPORT REQUESTED

Up to $2,588,776 may be available annually to fund up to seven (7) LEAH grants. Based on historical data and expected funding levels, it is anticipated that the mean grant award will be approximately $369,825 per year for up to five (5) years. Applicants may apply for a ceiling amount of up to $441,155 per year. In the year in which a training program hosts the annual meeting, the award ceiling amount is $471,155. Each grantee should plan to organize a meeting one (1) time during the five (5) year project cycle and will include $30,000 in meeting costs in their budget for that year. See below for further instructions on how to determine a budget for your program.

Applicants should budget funds to attend an annual grantee/partner meeting with key stakeholders, and participate in conference calls as needed.

Describe briefly what additional resources are needed to accomplish the stated goals and objectives, i.e., what is requested through project support and why.

- All budgets must provide satisfactory details to fully explain and justify the resources needed to accomplish the training objectives. This justification must provide explicit qualitative and quantitative documentation of required resources, productivity, and expected outcomes. Components to highlight include current strengths, number of long-term trainees (specifying the number of masters, pre-doctoral and post-doctoral trainees), proposed program activities, Title V activities, and continuing education efforts.

- Budget justification must document support provided to long-term trainees either through this grant or through other sources.

- Programs must fully justify their requests by describing and identifying goals, objectives, activities, and outcomes that will be achieved by the program during the project period. It must be documented that the program plays a significant role in regional and/or national matters, including the extent to which the graduates have played major leadership roles related to maternal and child health.

- Grantee budgets may reflect certain economic factors that may cause amounts to be higher or lower than average costs, e.g., special program emphasis, features or accomplishments, cost of living, type of institution of higher learning, community resources, etc.

Applications must include a general plan to develop and convene annual meeting at least once during the five-year project period. Funds will be made available on a rotating basis to one grantee each year to host this meeting. Responsibility of the host program includes arrangements and payment for the program, speakers, meeting logistics and lodging, plus meeting meals in lieu of one-half the per diem, for approximately $30,000.

## E. EVALUATIVE MEASURES

Evaluation and self-assessment are critically important for quality improvement and assessing the value-added contribution of Title V investments. Consequently, discretionary grant projects, including training projects, are expected to incorporate a carefully designed and well-planned evaluation protocol capable of demonstrating and documenting measurable progress toward achieving the stated goals. The measurement of progress toward goals must focus on systems, health and performance outcome indicators, rather than solely on intermediate process measures. The protocol must be based on a clear rationale relating to the identified needs of the target population with project goals, grant activities, and evaluation measures. A project lacking a complete and well-conceived evaluation protocol may not be funded. A formal plan for evaluating the LEAH program must address how the major goals and objectives of the project will be achieved.

If there is any possibility that an applicant's evaluation may involve human subjects research as described in 45 CFR part 46, the applicant must comply with the regulations for the protection of human subjects as applicable.

Monitoring and evaluation activities must be ongoing and, to the extent feasible, must be structured to gain information which is quantifiable and which permits objective rather than subjective judgments. Explain what data will be collected, the methods for collection and the manner in which data will be analyzed and reported. Data analysis and reporting must facilitate evaluation of the project outcomes.

The applicant must describe who on the project will be responsible for refining and collecting, and analyzing data for the evaluation and how the applicant will make changes to the program based on evaluation findings. The applicant must present a plan for collecting the data elements described in Appendix B, MCHB Administrative Forms and Performance Measures.

## F. IMPACT

The applicant must document the extent and effectiveness of plans for dissemination of project results and the extent to which project results may be national in scope, and the degree to which the project activities are shared with other stakeholders to strengthen the MCH network.

**Development and Dissemination of Educational Resources**
As programs revise and develop new curricular materials, teaching models, and other educational resources and references in adolescent health in response to new research findings and developments in the field of adolescent health, they must disseminate these products to adolescent, clinical and public health programs or other relevant programs in order to promote enhanced attention to this specialized area.

**MCH Network Development**
The applicant must articulate a plan for demonstrating and teaching others to promote enhanced access to MCH expertise, values, initiatives and products through increased visibility and outreach. Within this plan, emphasis must be placed on how MCH Trainees and alumni will be connected to one another, adding to the network of MCH professionals working together to improve maternal and child health. Efforts to assure trainee involvement in wider MCH related opportunities must be clearly described, along with other methods to develop the MCH identity amongst trainees.

**x. *Program Specific Forms***

*1) Performance Standards for Special Projects of Regional or National Significance (SPRANS) and Other MCHB Discretionary Projects*

The Health Resources and Services Administration (HRSA) has modified its reporting requirements for SPRANS projects, CISS projects, and other grant programs administered by the Maternal and Child Health Bureau (MCHB) to include national performance measures that were developed in accordance with the requirements of the Government Performance and Results Act (GPRA) of 1993 (Public Law 103-62). This Act requires the establishment of measurable goals for federal programs that can be reported as part of the budgetary process, thus linking funding decisions with performance. Performance measures for states have also been established under the Block Grant provisions of Title V of the Social Security Act, the MCHB's authorizing legislation. Performance measures for other MCHB-funded grant programs have been approved by the Office of Management and Budget and are primarily based on existing or administrative data that projects should easily be able to access or collect. An electronic system for reporting these data elements has been developed and is now available.

*2) Performance Measures for the LEAH Training Program and Submission of Administrative Data*

To prepare successful applicants of their reporting requirements, the administrative forms and performance measures are presented in the appendices of this funding opportunity announcement. Applicants should be aware that in addition to the existing MCH Training and LEAH-specific performance measure reporting requirements, including, they are responsible for completing all required information. In summary, the forms and performance measures for this program are:

- Form 1, MCHB Project Budget Details
- Form 2, Project Funding Profile
- Form 4, Project Budget and Expenditures by Types of Services
- Form 6, Abstract
- Form 7, Discretionary Grant Project Summary Data
- Project Performance/Outcome Measures(See Individual PM's below)
  - PM07: The degree to which MCHB-funded programs ensure family, youth, and consumer participation in program and policy activities
  - PM08: The percentage of graduates of MCHB long-term training programs that demonstrate field leadership after graduation
  - PM09: The percentage of participants in MCHB long-term training programs who are from underrepresented racial and ethnic groups

- PM10: The degree to which MCHB-funded programs have incorporated cultural and linguistic competence elements into their policies, guidelines, contracts, and training
- PM59: The degree to which a training program collaborates with State Title V agencies, other MCH or MCH-related programs.
- PM60: The percent of long-term trainees who, at 1, 5 and 10 years post training, work in an interdisciplinary manner to serve the MCH population (e.g., individuals with disabilities and their families, adolescents and their families, etc.)
- PM64: The degree to which the LEAH program incorporates adolescents and parents from diverse ethnic and cultural backgrounds as advisors and participants in program activities.
- PM84: The percent of long-term training graduates who are engaged in work related to MCH populations.
- PM85: The degree to which MCH long-term training grantees engage in policy development, implementation, and evaluation.

- Training Data Form – All Sections
- Products, Publications and Submissions Data Form

If there is any possibility that an applicant's performance evaluation may involve human subjects research as described in 45 CFR part 46, the applicant must comply with the regulations for the protection of human subjects as applicable.

Monitoring and evaluation of performance measure activities must be ongoing and, to the extent feasible, must be structured to gain information which is quantifiable and which permits objective rather than subjective judgments.

Discretionary grant projects, including training projects, are expected to incorporate a carefully designed and well-planned protocol capable of demonstrating and documenting measurable progress toward MCH Training Performance Measures. The measurement of progress toward goals must focus on systems, health and performance outcome indicators, rather than solely on intermediate process measures. The protocol must be based on a clear rationale relating to the identified needs of the target population with project goals, grant activities, and evaluation measures. A project lacking a complete and well-conceived evaluation protocol may not be funded. A formal plan for evaluating the LEAH program must address how the major goals and objectives of the project will be achieved.

The applicant must describe who on the project will be responsible for refining and collecting, and analyzing data for the evaluation and how the applicant will make changes to the program based on evaluation findings. The applicant must present a plan for collecting the data elements described in Appendix B, MCHB Administrative Forms and Performance Measures.

**xi.** ***Attachments***

Please provide the following items to complete the content of the application. Please note that these are supplementary in nature, and are not intended to be a continuation of the project narrative. **Each attachment must be clearly labeled**. Unless otherwise noted, all attachments count against the 80-page limit.

**Attachment 1: Chart/Table of Partners and Collaboration:** Please provide a chart of letters of collaboration between the proposed program and collaborating departments,

institutions, organizations or agencies. The chart must provide the following information: Institution, Person as appropriate, Responsibilities/Activities agreed to be provided, Date, Type of commitment (e.g., in kind, dollars, staff, equipment), and how the letters can be accessed.

**Attachment 2: Map(s):** Provide a map which indicates the location(s) and settings of primary training activities.

**Attachment 3: Organizational Chart:** Provide a one-page figure that depicts the organizational structure of the project, including subcontractors and other significant collaborators.

**Attachment 4: Curriculum:** Provide a syllabus or other curriculum description as appropriate for the LEAH program. The syllabus must include descriptions of courses, workshops, seminars, and experiences.

**Attachment 5: Position Descriptions of Key Personnel**: Position descriptions that include the roles, responsibilities, and qualifications of proposed staff can be limited to a paragraph in length, not to exceed one (1) page. Because of the 80 page limit of this application, only include key personnel.

**Attachment 6: Summary Progress Report (REQUIRED FOR COMPETING CONTINUATIONS):** A summary progress report may be less than, but must not exceed **20 pages, including the narrative and all attachments**, and must be submitted by competing continuation applicants. New applicants under this announcement have the option of submitting a report covering the preceding five (5) years for activities that are related to their training program for which support is being requested. Submit this progress report with the application, as an attachment.

For current MCHB training projects, use the outline below to structure your summary progress report. For new applicants, use the summary progress report to demonstrate your capacity to implement a LEAH training project.

The statement will include:

i. **The period covered** in the report.

ii. **Specific Objectives:** Briefly summarize the specific objectives of the project as actually funded.

iii. **Results:** Describe the program activities conducted for each objective and the accomplishments. Include negative results or technical problems that may be important. Include summary performance measure data. Identify, in tabular form, by year, the length of training, numbers, disciplines, and levels of trainees in the program. Each MCH-supported trainee who completed training during the approved project period should be listed along with his/her racial/ethnic identity and current employment. Separate identification should be made of continuing education attendees; these attendees should not be counted as short-term trainees.

iv. **Evaluation:** Enumerate the quantitative and qualitative measures used to evaluate the activities and objectives. Specify project outcomes and the degree to which stated objectives were achieved. Include any important modifications to your original plans.

v. **Title V Program Relationship:** Describe the activities related to, or resulting from, established relationships of the program and faculty with state and local Title V agencies and programs in the community, state, and region.

vi. **Regional and National Significance:** Describe significant contributions of the program beyond the state in which it is located.

vii. **Value Added:** Explain how this training grant has made a difference in your program, department, university, and beyond. What accomplishments and benefits would not have been possible without this support?

**Attachments 7–15: Other relevant documents,** such as budgets and budget justifications for subcontracts, etc.

### 3. Submission Dates and Times

**Application Due Date**
The due date for applications under this funding opportunity announcement is **March 16, 2012 by 8:00 P.M. ET.** Applications completed online are considered formally submitted when the application has been successfully transmitted electronically by your organization's Authorized Organization Representative (AOR) through Grants.gov and has been validated by Grants.gov on or before the deadline date and time.

**Receipt acknowledgement**: Upon receipt of an application, Grants.gov will send a series of email messages advising you of the progress of your application through the system. The first will confirm receipt in the system; the second will indicate whether the application has been successfully validated or has been rejected due to errors; the third will be sent when the application has been successfully downloaded at HRSA; and the fourth will notify the applicant of the Agency Tracking Number assigned to the application.

The Chief Grants Management Officer (CGMO) or designee may authorize an extension of published deadlines when justified by circumstances such as natural disasters (e.g., floods or hurricanes) or other disruptions of services, such as a prolonged blackout. The CGMO or designee will determine the affected geographical area(s).

**Late applications:**
Applications which do not meet the criteria above are considered late applications and will not be considered in the current competition.

### 4. Intergovernmental Review

The MCH Training Program is not a program subject to the provisions of Executive Order 12372, as implemented by 45 CFR 100.

## 5. Funding Restrictions

1) **Concurrent Income -** In most instances stipends may not be granted to persons receiving a concurrent salary, fellowship or traineeship stipend, or other financial support related to his/her training or employment.
2) **Non-related Duties -** The training institution shall not require trainees or fellows to perform any duties which are not directly related to the purpose of the training for which the grant was awarded.
3) **Field Training -** Training institutions may not utilize grant funds to support field training, except when such training is part of the specified requirements of a degree program, or is authorized in the approved application.
4) **Other -** Grant funds may **not** be used: (a) for the support of any trainee who would not, in the judgment of the institution, be able to use the training or meet the minimum qualifications specified in the approved plan for the training; (b) to continue the support of a trainee who has failed to demonstrate satisfactory participation; or (c) for support of candidates for undergraduate or pre-professional degrees, or the basic professional degree.

Indirect costs under training grants to organizations other than state, local or Indian tribal governments will be budgeted and reimbursed at 8% of modified total direct costs rather than on the basis of a negotiated cost agreement, and are not subject to upward or downward adjustment. Direct cost amounts for equipment (capital expenditures), tuition and fees, and subgrants and contracts in excess of $25,000 are excluded from the actual direct cost base for purposes of this calculation.

**Salary Limitation:** The Consolidated Appropriations Act, 2012 (P.L. 112-74) enacted December 23, 2011, limits the salary amount that may be awarded and charged to HRSA grants and cooperative agreements. Award funds may not be used to pay the salary of an individual at a rate in excess of Executive Level II. The Executive Level II salary of the Federal Executive Pay scale is $179,700. This amount reflects an individual's base salary exclusive of fringe and any income that an individual may be permitted to earn outside of the duties to the applicant organization. This salary limitation also applies to subawards/subcontracts under a HRSA grant or cooperative agreement.

Per Division F, Title V, Section 503 of the Consolidated Appropriations Act, 2012 (P.L. 112-74) enacted December 23, 2011 (a) No part of any appropriation contained in this Act or transferred pursuant to section 4002 of Public Law 111-148 shall be used, other than for normal and recognized executive-legislative relationships, for publicity or propaganda purposes, for the preparation, distribution, or use of any kit, pamphlet, booklet, publication, electronic communication, radio, television, or video presentation designed to support or defeat the enactment of legislation before the Congress or any State or local legislature or legislative body, except in presentation to the Congress or any State or local legislature itself, or designed to support or defeat any proposed or pending regulation, administrative action, or order issued by the executive branch of any State or local government, except in presentation to the executive branch of any State or local government itself. (b) No part of any appropriation contained in this Act or transferred pursuant to section 4002 of Public Law 111-148 shall be used to pay the salary or expenses of any grant or contract recipient, or agent acting for such recipient, related to any activity designed to influence the enactment of legislation, appropriations, regulation, administrative action, or Executive order proposed or pending before the Congress or any State

government, State legislature or local legislature or legislative body, other than for normal and recognized executive-legislative relationships or participation by an agency or officer of a State, local or tribal government in policymaking and administrative processes within the executive branch of that government. (c) The prohibitions in subsections (a) and (b) shall include any activity to advocate or promote any proposed, pending or future Federal, State or local tax increase, or any proposed, pending, or future requirement or restriction on any legal consumer product, including its sale or marketing, including but not limited to the advocacy or promotion of gun control.

Per Division F, Title V, Section 523 of the Consolidated Appropriations Act, 2012 (P.L. 112-74) enacted December 23, 2011, no funds appropriated in this Act shall be used to carry out any program of distributing sterile needles or syringes for the hypodermic injection of any illegal drug.

Per Division F, Title V, Section 508 (a) None of the funds made available in this Act may be used for (1) the creation of a human embryo or embryos for research purposes; or (2) research in which a human embryo or embryos are destroyed, discarded, or knowingly subjected to risk of injury or death greater than that allowed for research on fetuses in utero under 45 CFR 46.204(b) and section 498(b) of the Public Health Service Act (42 U.S.C. 289g(b)). The term ‘‘human embryo or embryos’’ includes any organism, not protected as a human subject under 45 CFR 46 as of the date of the enactment of this Act (December 23, 2011), that is derived by fertilization, parthenogenesis, cloning, or any other means from one or more human gametes or human diploid cells.

### 6. Other Submission Requirements

As stated in Section IV.1, except in very rare cases HRSA will no longer accept applications in paper form. Applicants submitting for this funding opportunity are ***required*** to submit ***electronically*** through Grants.gov. To submit an application electronically, please use the APPLY FOR GRANTS section at http://www.grants.gov. When using Grants.gov you will be able to download a copy of the application package, complete it off-line, and then upload and submit the application via the Grants.gov site.

It is essential that your organization ***immediately register*** in Grants.gov and become familiar with the Grants.gov site application process. If you do not complete the registration process you will be unable to submit an application. The registration process can take up to one month.

To be able to successfully register in Grants.gov, it is necessary that you complete all of the following required actions:

- Obtain an organizational Data Universal Numbering System (DUNS) number
- Register the organization with Central Contractor Registration (CCR)
- Identify the organization’s E-Business Point of Contact (E-Biz POC)
- Confirm the organization’s CCR “Marketing Partner ID Number (M-PIN)” password
- Register and approve an Authorized Organization Representative (AOR)
- Obtain a username and password from the Grants.gov Credential Provider

Instructions on how to register, tutorials and FAQs are available on the Grants.gov web site at http://www.grants.gov. Assistance is also available 24 hours a day, 7 days a week (excluding

federal holidays) from the Grants.gov help desk at support@grants.gov or by phone at 1-800-518-4726. Applicants should ensure that all passwords and registration are current well in advance of the deadline.

**It is incumbent on applicants to ensure that the AOR is available to submit the application to HRSA by the published due date. HRSA will not accept submission or re-submission of incomplete, rejected, or otherwise delayed applications after the deadline.** Therefore, you are urged to submit your application in advance of the deadline. If your application is rejected by Grants.gov due to errors, you must correct the application and resubmit it to Grants.gov before the deadline date and time. Deadline extensions will not be provided to applicants who do not correct errors and resubmit before the posted deadline.

**If, for any reason, an application is submitted more than once prior to the application due date, HRSA will only accept the applicant's last validated electronic submission prior to the application due date as the final and only acceptable submission of any competing application submitted to Grants.gov.**

**Tracking your application:** It is incumbent on the applicant to track their application by using the Grants.gov tracking number (GRANTXXXXXXXX) provided in the confirmation email from Grants.gov. More information about tracking your application can be found at https://apply07.grants.gov/apply/checkApplStatus.faces. Be sure your application is validated by Grants.gov prior to the application deadline.

## V. Application Review Information

### 1. Review Criteria

Procedures for assessing the technical merit of applications have been instituted to provide for an objective review of applications and to assist the applicant in understanding the standards against which each application will be judged. Critical indicators have been developed for each review criterion to assist the applicant in presenting pertinent information related to that criterion and to provide the reviewer with a standard for evaluation. Review criteria are outlined below with specific detail and scoring points.

Review Criteria are used to review and rank applications. All LEAH Program applications will be reviewed and ranked according to the following six (6) criteria:

| | | |
|---|---|---|
| Criterion 1. | Purpose/Need | 5 points |
| Criterion 2. | Methodology/Response | 40 points |
| Criterion 3. | Evaluative Measures | 10 points |
| Criterion 4. | Impact | 10 points |
| Criterion 5. | Resources/Capabilities | 20 points |
| Criterion 6. | Support Requested | 15 points |
| Total | | 100 points |

***CRITERION 1: PURPOSE/NEED (5 points)***

This criterion corresponds to Section A. PURPOSE/NEED of the program narrative in this

funding opportunity announcement. Evaluation of the described purpose and need for the proposed project, including (a) the critical national, regional, and local needs that the LEAH training program will address pertaining to those adolescents; (b) how the project will address the identified needs and the degree to which this program addresses the purpose of the LEAH grant program; and (c) demonstration of a strong knowledge of health and related issues for the adolescent population.

***CRITERION 2: METHODOLOGY/RESPONSE (40 points)***

The extent to which the proposed project responds to the Section B. METHODOLOGY/ RESPONSE of the program narrative, and the clarity of the proposed goals and objectives. The extent to which the proposed activities (scientific or other) meet the goals of the LEAH training program, and address the goals and attain project objectives.

***Goals and Objectives (10 points)***

- *The degree to which the project goals and objectives address the stated needs/purpose outlined in Section A and the objectives are time-framed and measurable.*

***Trainee Recruitment and Retention (10 points)***

- *Completeness, strength, and innovation of recruiting and retention plans and/or strategies, including those focused on racially, ethnically and culturally diverse trainees and ensuring all LEAH core disciplines are reached.*
- *Completeness of plans for tracking field leadership post-graduation.*
- *Plans addressing continuing education, including medium-term and short-term trainee programs and activities.*

***Training elements (Training program design, clinical training, MCH Curriculum): (20 points)***

- *The extent to which the approach to training is thoughtful, logical and innovative.*
- *The extent to which the project utilizes the MCH Leadership competencies framework and assessment of trainees and faculty on the leadership competencies.*
- *The extent to which the project addresses didactic and experiential clinical training for trainees from clinical disciplines, and clinical observation experiences for non-clinical disciplines, including diverse clinical rotations and interactions with interdisciplinary professionals.*
- *The strength and feasibility of the proposed plan for development of trainee understanding, use and translation of research, including collaborative research approach.*
- *The extent to which the project provides trainees the opportunity to practice, demonstrate, and document effective teaching and communication, especially with diverse constituencies.*
- *Evidence that the curricula address issues of cultural and linguistic competence and diversity.*
- *The extent to which effective and innovative ways address interdisciplinary education around adolescents.*
- *The extent to which the MCH Life course framework is used in teaching.*
- *The extent to which the project integrates a public health perspective in the planned curricula.*

- *The extent to which the curricula address technology, innovation, and emerging issues.*
- *The effectiveness and strength of the collaboration with those outside of the university – (e.g., adolescents and their families, MCH or other appropriate agencies, other MCH Partners) through included agreed-upon collaboration.*
- *Coordination of the project's plan and objectives with the MCH Training Strategic Plan.*

***CRITERION 3: EVALUATIVE MEASURES (10 points)***

This section corresponds to the Section E. EVALUATIVE MEASURES of the program narrative. The effectiveness of the method proposed to monitor and evaluate the project results. Evaluative measures must be able to assess: 1) to what extent the program objectives have been met*;* and 2) to what extent these can be attributed to the project.

- *The strength and feasibility of the evaluation strategy to measure project objectives and proposed performance measures*
- *Strength of the proposed project's evaluation plan, including tracking and reporting on the accomplishments of former trainees*
- *The extent to which data and evaluation informs changes to the project based on evaluation findings*
- *The extent to which the applicant presents a plan for collecting the data element, methods of data collection, required by MCHB described in Appendix A - MCHB Administrative Forms and Performance Measures*

***CRITERION 4: IMPACT (10 points)***

This section corresponds to the Section F. IMPACT of the program narrative. The extent and effectiveness of plans for dissemination of project results, the extent to which project results may be national in scope, and the degree to which the project activities are shared with other stakeholders.

- *Effectiveness of the dissemination plan to share curricula, assessment and other tools, training approaches, research findings (if any), and successes.*
- *Effectiveness of the dissemination plan to share the above mentioned items with MCHB funded entities.*
- *Effectiveness of a plan for strengthening the MCH network through connections of program faculty, staff, trainees and alumni with the broader MCH network.*

***CRITERION 5: RESOURCES/CAPABILITIES (20 points)***

This criterion corresponds to Section C. RESOURCES/CAPABILITIES of the program narrative. This is an evaluation of the proposed administrative structure, governance, relationships of the participants, and resources to conduct the proposed project, including the extent to which the project's personnel are qualified by training and/or experience to implement and carry out the project, including the following:

***Faculty***

- *Strength of proposed project faculty and staff as evidenced by their qualifications and experience for teaching leadership education in adolescent health, including relevant*

*education and experience of the project director and representation of the specified disciplines required for faculty.*
- *Extent to which faculty members are effective in recruiting, teaching, collaborating, mentoring students and serving as leaders in the field.*
- *Effectiveness of the plan for recruiting racially, ethnically and culturally diverse faculty.*

***Organizational:***
- *Evidence of administrative and organizational capacity to conduct the proposed project (e.g., the physical resources described are adequate to perform the training, existing resources to support the types of educational methods described).*
- *Extent of experience in providing interdisciplinary graduate training in the disciplines identified in the funding opportunity announcement for MCH LEAH.*
- *Adequacy of the project setting and training sites.*
- *Documentation of relevant affiliation/collaborative agreements with key partners.*
- *Planned collaboration with those outside of the university (i.e., adolescents and their families and/or consumers, MCH or other appropriate state agencies and resources, and other MCHB investments).*

***CRITERION 6: SUPPORT REQUESTED (15 points)***

This criterion corresponds to Section D. SUPPORT REQUESTED of the program narrative. The proposed budget for each year of the project period is reasonable and relational to the objectives, complexity of the activities and the anticipated results for the project.

***Overall:***
- *Are the costs outlined in the budget and required resources sections reasonable given the scope of work?*
- *Are the budget line items well described and justified in the budget justification?*

***Trainee, faculty, and staffing related costs:***
- *Does the applicant meet the minimum threshold of trainees and faculty disciplines outlined in the Support Requested section for their requested range of funding?*
- *Is the number of doctoral and post-doctoral trainee stipends reasonably described in the budget in comparison to masters-level trainee stipends?*
- *Are key personnel devoting adequate time to the project to achieve project objectives?*
- *Are there innovative national efforts, with an emphasis on adolescent health, described in the budget?*
- *Are there funds allocated for applicants to attend an annual grantee meeting?*
- *Does the applicant include managing the LEAH annual meeting for one year during the five-year grant period?*

**2. Review and Selection Process**

The Division of Independent Review is responsible for managing objective reviews within HRSA. Applications competing for federal funds receive an objective and independent review performed by a committee of experts qualified by training and experience in particular fields or disciplines related to the program being reviewed. In selecting review committee members, other factors in addition to training and experience may be considered to improve the balance of

the committee, e.g., geographic distribution. Each reviewer is screened to avoid conflicts of interest and is responsible for providing an objective, unbiased evaluation based on the review criteria noted above. The committee provides expert advice on the merits of each application to program officials responsible for final selections for award.

Applications that pass the initial HRSA eligibility screening will be reviewed and rated by a panel based on the program elements and review criteria presented in relevant sections of this funding opportunity announcement. The review criteria are designed to enable the review panel to assess the quality of a proposed project and determine the likelihood of its success. The criteria are closely related to each other and are considered as a whole in judging the overall quality of an application.

### 3. Anticipated Announcement and Award Dates

It is anticipated that awards will be announced prior to the start date of July 1, 2012.

## VI. Award Administration Information

### 1. Award Notices

Each applicant will receive written notification of the outcome of the objective review process, including a summary of the expert committee's assessment of the application's strengths and weaknesses, and whether the application was selected for funding. Applicants who are selected for funding may be required to respond in a satisfactory manner to Conditions placed on their application before funding can proceed. Letters of notification do not provide authorization to begin performance.

The Notice of Award sets forth the amount of funds granted, the terms and conditions of the award, the effective date of the award, the budget period for which initial support will be given, the non-federal share to be provided (if applicable), and the total project period for which support is contemplated. Signed by the Grants Management Officer, it is sent to the applicant's Authorized Organization Representative, and reflects the only authorizing document. It will be sent prior to the start date of July 1, 2012.

### 2. Administrative and National Policy Requirements

Successful applicants must comply with the administrative requirements outlined in 45 CFR Part 74 Uniform Administrative Requirements for Awards and Subawards to Institutions of Higher Education, Hospitals, Other Nonprofit Organizations, and Commercial Organizations or 45 CFR Part 92 Uniform Administrative Requirements For Grants And Cooperative Agreements to State, Local, and Tribal Governments, as appropriate.

HRSA grant and cooperative agreement awards are subject to the requirements of the HHS Grants Policy Statement (HHS GPS) that are applicable based on recipient type and purpose of award. This includes, as applicable, any requirements in Parts I and II of the HHS GPS that apply to the award. The HHS GPS is available at http://www.hrsa.gov/grants/. The general terms and conditions in the HHS GPS will apply as indicated unless there are statutory,

regulatory, or award-specific requirements to the contrary (as specified in the Notice of Award).

**Human Subjects Protection**
Federal regulations (45 CFR 46) require that applications and proposals involving human subjects must be evaluated with reference to the risks to the subjects, the adequacy of protection against these risks, the potential benefits of the research to the subjects and others, and the importance of the knowledge gained or to be gained. If research involving human subjects is anticipated, you must meet the requirements of the DHHS regulations to protect human subjects from research risks as specified in the Code of Federal Regulations, Title 45 – Public Welfare, Part 46 – Protection of Human Subjects (45 CFR 46), available online at www.hhs.gov/ohrp/humansubjects/guidance/45cfr46.html.

**Financial Conflict of Interest**
HHS requires awardees and investigators to comply with the requirements of 42 CFR Part 50, Subpart F, "Responsibility of Applicants for Promoting Objectivity in Research for which PHS Funding is Sought." A Final Rule amending this PHS regulation (and the companion regulation at 45 CFR part 94, "Responsible Prospective Contractors," imposing similar requirements for research contracts) was published on August 25, 2011 in the Federal Register (http://www.gpo.gov/fdsys/pkg/FR-2011-08-25/pdf/2011-21633.pdf). An Institution applying for or receiving PHS funding from a grant or cooperative agreement that is covered by the rule must be in full compliance with all of the revised regulatory requirements no later than August 24, 2012, and immediately upon making its institutional Financial Conflict of Interest (FCOI) policy publicly accessible as described in the regulation.

**Trafficking in Persons**
Awards issued under this funding opportunity announcement are subject to the requirements of Section 106(g) of the Trafficking Victims Protection Act of 2000, as amended (22 U.S.C. 7104). For the full text of the award term, go to http://www.hrsa.gov/grants/trafficking.html. If you are unable to access this link, please contact the Grants Management Specialist identified in this funding opportunity to obtain a copy of the Term.

**Smoke-Free Workplace**
The Public Health Service strongly encourages all award recipients to provide a smoke-free workplace and to promote the non-use of all tobacco products. Further, Public Law 103-227, the Pro-Children Act of 1994, prohibits smoking in certain facilities (or in some cases, any portion of a facility) in which regular or routine education, library, day care, health care or early childhood development services are provided to children.

**Cultural and Linguistic Competence**
HRSA programs serve culturally and linguistically diverse communities and multiple cultures. Although race and ethnicity are often thought to be dominant elements of culture, HRSA funded programs embrace a broader definition to include language, gender, socio-economic status, sexual orientation and gender identity, physical and mental capacity, age, religion, housing status, and regional differences. Organizational behaviors, practices, attitudes, and policies across all HRSA-supported entities respect and respond to the cultural diversity of communities, clients and students served. HRSA is committed to ensuring access to quality health care for all. Quality care means access to services, information, materials delivered by competent providers in a manner that factors in the language needs, cultural richness, and

diversity of populations served. Quality also means that, where appropriate, data collection instruments used should adhere to culturally competent and linguistically appropriate norms. For additional information and guidance, refer to the National Standards for Culturally and Linguistically Appropriate Services in Health Care (CLAS) published by HHS and available online at http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlID=15. Additional cultural competence and health literacy tools, resources and definitions are available online at http://www.hrsa.gov/culturalcompetence and http://www.hrsa.gov/healthliteracy.

**Healthy People 2020**

Healthy People 2020 is a national initiative led by HHS that sets priorities for all HRSA programs. The initiative has four overarching goals: (1) attain high-quality, longer lives free of preventable disease, disability, injury, and premature death; (2) achieve health equity, eliminate disparities, and improve the health of all groups; (3) create social and physical environments that promote good health for all; and (4) promote quality of life, healthy development, and healthy behaviors across all life stages. The program consists of over 40 topic areas, containing measurable objectives. HRSA has actively participated in the work groups of all the topic areas and is committed to the achievement of the Healthy People 2020 goals. More information about Healthy People 2020 may be found online at http://www.healthypeople.gov/.

**National HIV/AIDS Strategy (NHAS)**

The National HIV/AIDS Strategy (NHAS) has three primary goals: 1) reducing the number of people who become infected with HIV, 2) increasing access to care and optimizing health outcomes for people living with HIV, and 3) reducing HIV-related health disparities. The NHAS states that more must be done to ensure that new prevention methods are identified and that prevention resources are more strategically deployed. Further, the NHAS recognizes the importance of early entrance into care for people living with HIV to protect their health and reduce their potential of transmitting the virus to others. HIV disproportionately affects people who have less access to prevention, care and treatment services and, as a result, often have poorer health outcomes. Therefore, the NHAS advocates adopting community-level approaches to identify people who are HIV-positive but do not know their serostatus and reduce stigma and discrimination against people living with HIV.

To the extent possible, program activities should strive to support the three primary goals of the NHAS. As encouraged by the NHAS, programs should seek opportunities to increase collaboration, efficiency, and innovation in the development of program activities to ensure success of the NHAS. Programs providing direct services should comply with federally-approved guidelines for HIV Prevention and Treatment (see http://www.aidsinfo.nih.gov/Guidelines/Default.aspx as a reliable source for current guidelines). More information can also be found at http://www.whitehouse.gov/administration/eop/onap/nhas

**Health IT**

Health information technology (Health IT) provides the basis for improving the overall quality, safety and efficiency of the health delivery system. HRSA endorses the widespread and consistent use of health IT, which is the most promising tool for making health care services more accessible, efficient and cost effective for all Americans.

**Related Health IT Resources:**

- Health Information Technology (HHS)
- What is Health Care Quality and Who Decides? (AHRQ)

## 3. Reporting

The successful applicant under this funding opportunity announcement must comply with the following reporting and review activities:

a. **Audit Requirements**
Comply with audit requirements of Office of Management and Budget (OMB) Circular A-133. Information on the scope, frequency, and other aspects of the audits can be found on the Internet at http://www.whitehouse.gov/omb/circulars_default.

b. **Payment Management Requirements**
Submit a quarterly electronic Federal Financial Report (FFR) Cash Transaction Report via the Payment Management System. The report identifies cash expenditures against the authorized funds for the grant or cooperative agreement. The FFR Cash Transaction Reports must be filed within 30 days of the end of each calendar quarter. Failure to submit the report may result in the inability to access award funds. Go to http://www.dpm.psc.gov for additional information.

c. **Status Reports**
1) **Federal Financial Report**. The Federal Financial Report (SF-425) is required within 90 days of the end of each budget period. The report is an accounting of expenditures under the project that year. Financial reports must be submitted electronically through EHB. More specific information will be included in the Notice of Award.

2) **Progress Report**(s). The awardee must submit a progress report to HRSA on an annual basis. Submission and HRSA approval of your Progress Report(s) triggers the budget period renewal and release of subsequent year funds. This report demonstrates grantee progress on program-specific goals. Further information will be provided in the award notice.

3) **Final Report(s).** A final report is due within 90 days after the project period ends. The final report collects program-specific goals and progress on strategies; core performance measurement data; impact of the overall project; the degree to which the grantee achieved the mission, goal and strategies outlined in the program; grantee objectives and accomplishments; barriers encountered; and responses to summary questions regarding the grantee's overall experiences over the entire project period. The final report must be submitted on-line by awardees in the Electronic Handbooks system at https://grants.hrsa.gov/webexternal/home.asp.

*4)* **Performance Report(s).** The Health Resources and Services Administration (HRSA) has modified its reporting requirements for SPRANS projects, CISS projects, and other grant programs administered by the Maternal and Child Health Bureau (MCHB) to include national performance measures that were developed in accordance with the requirements of the Government Performance and Results Act (GPRA) of 1993 (Public Law 103-62). This Act requires the establishment of measurable goals for federal

programs that can be reported as part of the budgetary process, thus linking funding decisions with performance. Performance measures for states have also been established under the Block Grant provisions of Title V of the Social Security Act, the MCHB's authorizing legislation. Performance measures for other MCHB-funded grant programs have been approved by the Office of Management and Budget and are primarily based on existing or administrative data that projects should easily be able to access or collect.

**(1) Performance Measures and Program Data**

To prepare applicants for these reporting requirements, the designated performance measures for this program and other program data collection are presented in the appendices of this funding opportunity announcement.

**(2) Performance Reporting**

Successful applicants receiving grant funds will be required, within 120 days of the Notice of Award (NoA), to register in HRSA's Electronic Handbooks (EHBs) and electronically complete the program specific data forms that appear in the appendices of this funding opportunity announcement. This requirement entails the provision of budget breakdowns in the financial forms based on the grant award amount, the project abstract and other grant summary data as well as providing objectives for the performance measures.

Performance reporting is conducted for each grant year of the project period. Grantees will be required, within 120 days of the NoA, to enter HRSA's EHBs and complete the program specific forms. This requirement includes providing expenditure data, finalizing the abstract and grant summary data as well as finalizing indicators/scores for the performance measures.

**(3) Project Period End Performance Reporting**

Successful applicants receiving grant funding will be required, within 90 days from the end of the project period, to electronically complete the program specific data forms that appear in the appendices of this funding opportunity announcement. The requirement includes providing expenditure data for the final year of the project period, the project abstract and grant summary data as well as final indicators/scores for the performance measures.

**d. Transparency Act Reporting Requirements**

New awards ("Type 1") issued under this funding opportunity announcement are subject to the reporting requirements of the Federal Funding Accountability and Transparency Act (FFATA) of 2006 (Pub. L. 109–282), as amended by section 6202 of Public Law 110–252, and implemented by 2 CFR Part 170. Grant and cooperative agreement recipients must report information for each first-tier subaward of $25,000 or more in federal funds and executive total compensation for the recipient's and subrecipient's five most highly compensated executives as outlined in Appendix A to 2 CFR Part 170 (FFATA details are available online at http://www.hrsa.gov/grants/ffata.html). Competing continuation awardees, etc. may be subject to this requirement and will be so notified in the Notice of Award.

## VII. Agency Contacts

Applicants may obtain additional information regarding business, administrative, or fiscal issues related to this funding opportunity announcement by contacting:

Pam Bell
Attn.: HRSA-12-015
HRSA Division of Grants Management Operations, OFAM
Parklawn Building, Room 11A-02
5600 Fishers Lane
Rockville, MD 20857
Telephone: (301) 443-3504
Fax: (301) 443-6686
Email: Pbell@hrsa.gov

Additional information related to the overall program issues and/or technical assistance regarding this funding announcement may be obtained by contacting:

Christopher Dykton
Attn: HRSA-12-015
Division of Research, Training, and Education
Maternal and Child Health Bureau, HRSA
Parklawn Building, Room 18A-55
5600 Fishers Lane
Rockville, MD 20857
Telephone: (301) 443-9534
Fax: (301) 443-4842
Email: Cdykton@hrsa.gov

Applicants may need assistance when working online to submit their application forms electronically. Applicants should always obtain a case number when calling for support. For assistance with submitting the application in Grants.gov, contact Grants.gov 24 hours a day, seven days a week, excluding federal holidays at:

Grants.gov Contact Center
Telephone: 1-800-518-4726
E-mail: support@grants.gov
iPortal: http://grants.gov/iportal

## VIII. Other Information

**Technical Assistance Conference Call/Webinar:**

Join us for a web-based question and answer session to address questions that you may have about the LEAH guidance on Friday, February 24, 2012, 3:00 PM - 4:00 PM Eastern Time (US and Canada) (Noon to 1pm Pacific Time).

Meeting Name: LEAH Guidance

Title: Q & A LEAH Guidance - web based
Date: Friday, February 24, 2012
Time: 3:00 PM - 4:00 PM Eastern Time (US and Canada) (Noon to 1pm Pacific Time)

**To join the online meeting:**

Go to https://hrsa.connectsolutions.com/irocha/
Enter as a guest and type your name.

Audio
Teleconference Line: 1-866-714-8978
Access Code: 864391 #

Connection trouble shooting: Imelda Rocha (irocha@hrsa.gov)
(301) 443-2927 Office.

**Informational Websites:**

**MCH Training Program Web Site**
**http://www.mchb.hrsa.gov/training**

**Leadership Education in Adolescent Health (LEAH) Training Program Web Site**
**http://leah.mchtraining.net/**

**National Plan for Maternal and Child Health Training 2015/2020 - Draft**
**http://www.mchb.hrsa.gov/training/strategic_plan.asp**

**MCH Leadership Competencies**
**http://leadership.mchtraining.net/**

**Healthy People 2020**
**http://www.healthypeople.gov/2020/topicsobjectives2020/default.aspx**

**Institute of Medicine (IOM)**
**"In the Nation's Compelling Interest: Ensuring Diversity in the Health Care Workforce"**
**http://www.iom.edu/Reports/2004/In-the-Nations-Compelling-Interest-Ensuring-Diversity-in-the-Health-Care-Workforce.aspx**

**Institute of Medicine (IOM)**
**"Adolescent Health Services: Missing Opportunities"**
**http://www.iom.edu/Reports/2008/Adolescent-Health-Services-Missing-Opportunities.aspx**

**Surgeon General's Health Reports**
**http://www.surgeongeneral.gov/library/**

**Bright Futures (American Academy of Pediatrics)**
**http://brightfutures.aap.org/web/**

**National Center for Cultural Competence**
**http://www11.georgetown.edu/research/gucchd/nccc/**

**Making Websites Accessible: Section 508 of the Rehabilitation Act**
**http://www.section508.gov/**

**Title V Information System (TVIS) website:**
**https://perfdata.hrsa.gov/mchb/tvisreports/default.aspx**

## IX. Tips for Writing a Strong Application

A concise resource offering tips for writing proposals for HHS grants and cooperative agreements can be accessed online at:
http://www.hhs.gov/asrt/og/grantinformation/apptips.html.

# Appendix A: MCHB Administrative Forms and Performance Measures

To prepare successful applicants for their future performance reporting requirements, the Administrative Forms and Performance Measures assigned to this MCHB program are presented below.

- Form 1, MCHB Project Budget Details
- Form 2, Project Funding Profile
- Form 4, Project Budget and Expenditures by Types of Services
- Form 6, MCH Abstract
- Form 7, Discretionary Grant Project Summary Data
- Performance Measures
    - PM07: The degree to which MCHB-funded programs ensure family, youth, and consumer participation in program and policy activities
    - PM08: The percentage of graduates of MCHB long-term training programs that demonstrate field leadership after graduation
    - PM09: The percentage of participants in MCHB long-term training programs who are from underrepresented racial and ethnic groups
    - PM10: The degree to which MCHB-funded programs have incorporated cultural and linguistic competence elements into their policies, guidelines, contracts, and training
    - PM59: The degree to which a training program collaborates with State Title V agencies, other MCH or MCH-related programs.
    - PM60: The percent of long-term trainees who, at 1, 5 and 10 years post training, work in an interdisciplinary manner to serve the MCH population (e.g., individuals with disabilities and their families, adolescents and their families, etc.)
    - PM64: The degree to which the LEAH program incorporates adolescents and parents from diverse ethnic and cultural backgrounds as advisors and participants in program activities.
    - PM84: The percent of long-term training graduates who are engaged in work related to MCH populations.
    - PM85: The degree to which MCH long-term training grantees engage in policy development, implementation, and evaluation.
- Training Data Form
- Products, Publications and Submissions Data Form

# FORM 1
## MCHB PROJECT BUDGET DETAILS FOR FY _____

| | | | |
|---|---|---|---|
| **1.** | **MCHB GRANT AWARD AMOUNT** | | $ |
| **2.** | **UNOBLIGATED BALANCE** | | $ |
| **3.** | **MATCHING FUNDS** | | $ |
| | (Required: Yes [ ] No [ ] If yes, amount) | | |
| | A. Local funds | $ | |
| | B. State funds | $ | |
| | C. Program Income | $ | |
| | D. Applicant/Grantee Funds | $ | |
| | E. Other funds: _____ | $ | |
| **4.** | **OTHER PROJECT FUNDS** (Not included in 3 above) | | $ |
| | A. Local funds | $ | |
| | B. State funds | $ | |
| | C. Program Income (Clinical or Other) | $ | |
| | D. Applicant/Grantee Funds (includes in-kind) | $ | |
| | E. Other funds (including private sector, e.g., Foundations) | $ | |
| **5.** | **TOTAL PROJECT FUNDS** (Total lines 1 through 4) | | $ |
| **6.** | **FEDERAL COLLABORATIVE FUNDS** | | $ |
| | (Source(s) of additional Federal funds contributing to the project) | | |
| | A. Other MCHB Funds (Do not repeat grant funds from Line 1) | | |
| | 1) Special Projects of Regional and National Significance (SPRANS) | $ | |
| | 2) Community Integrated Service Systems (CISS) | $ | |
| | 3) State Systems Development Initiative (SSDI) | $ | |
| | 4) Healthy Start | $ | |
| | 5) Emergency Medical Services for Children (EMSC) | $ | |
| | 6) Traumatic Brain Injury | $ | |
| | 7) State Title V Block Grant | $ | |
| | 8) Other: _____ | $ | |
| | 9) Other: _____ | $ | |
| | 10) Other: _____ | $ | |
| | B. Other HRSA Funds | | |
| | 1) HIV/AIDS | $ | |
| | 2) Primary Care | $ | |
| | 3) Health Professions | $ | |
| | 4) Other: _____ | $ | |
| | 5) Other: _____ | $ | |
| | 6) Other: _____ | $ | |
| | C. Other Federal Funds | | |
| | 1) Center for Medicare and Medicaid Services (CMS) | $ | |
| | 2) Supplemental Security Income (SSI) | $ | |
| | 3) Agriculture (WIC/other) | $ | |
| | 4) Administration for Children and Families (ACF) | $ | |
| | 5) Centers for Disease Control and Prevention (CDC) | $ | |
| | 6) Substance Abuse and Mental Health Services Administration (SAMHSA) | $ | |
| | 7) National Institutes of Health (NIH) | $ | |
| | 8) Education | $ | |
| | 9) Bioterrorism | | |
| | 10) Other: _____ | $ | |
| | 11) Other: _____ | $ | |
| | 12) Other _____ | $ | |
| **7.** | **TOTAL COLLABORATIVE FEDERAL FUNDS** | $ | |

## INSTRUCTIONS FOR COMPLETION OF FORM 1
## MCH BUDGET DETAILS FOR FY ____

Line 1. Enter the amount of the Federal MCHB grant award for this project.

Line 2. Enter the amount of carryover (e.g., unobligated balance) from the previous year's award, if any. New awards do not enter data in this field, since new awards will not have a carryover balance.

Line 3. If matching funds are required for this grant program list the amounts by source on lines 3A through 3E as appropriate. Where appropriate, include the dollar value of in-kind contributions.

Line 4. Enter the amount of other funds received for the project, by source on Lines 4A through 4E, specifying amounts from each source. Also include the dollar value of in-kind contributions.

Line 5. Displays the sum of lines 1 through 4.

Line 6. Enter the amount of other Federal funds received on the appropriate lines (A.1 through C.12) **other** than the MCHB grant award for the project. Such funds would include those from other Departments, other components of the Department of Health and Human Services, or other MCHB grants or contracts.

Line 6C.1. Enter only project funds from the Center for Medicare and Medicaid Services. Exclude Medicaid reimbursement, which is considered Program Income and should be included on Line 3C or 4C.

If lines 6A.8-10, 6B .4-6, or 6C.10-12 are utilized, specify the source(s) of the funds in the order of the amount provided, starting with the source of the most funds. .

Line 7. Displays the sum of lines in 6A.1 through 6C.12.

# FORM 2
# PROJECT FUNDING PROFILE

| | FY ____ | | FY ____ | | FY ____ | | FY ____ | | FY ____ | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Budgeted | Expended | Budgeted | Expended | Budgeted | Expended | Budgeted | Expended | Budgeted | Expended |
| **1** MCHB Grant Award Amount *Line 1, Form 2* | $ | $ | $ | $ | $ | $ | $ | $ | $ | $ |
| **2** Unobligated Balance *Line 2, Form 2* | $ | $ | $ | $ | $ | $ | $ | $ | $ | $ |
| **3** Matching Funds (If required) *Line 3, Form 2* | $ | $ | $ | $ | $ | $ | $ | $ | $ | $ |
| **4** Other Project Funds *Line 4, Form 2* | $ | $ | $ | $ | $ | $ | $ | $ | $ | $ |
| **5** Total Project Funds *Line 5, Form 2* | $ | $ | $ | $ | $ | $ | $ | $ | $ | $ |
| **6** Total Federal Collaborative Funds *Line 7, Form 2* | $ | $ | $ | $ | $ | $ | $ | $ | $ | $ |

# INSTRUCTIONS FOR THE COMPLETION OF FORM 2
# PROJECT FUNDING PROFILE

**Instructions:**

Complete all required data cells. If an actual number is not available, use an estimate. Explain all estimates in a note.

The form is intended to provide funding data at a glance on the estimated budgeted amounts and actual expended amounts of an MCH project.

For each fiscal year, the data in the columns labeled Budgeted on this form are to contain the same figures that appear on the Application Face Sheet (for a non-competing continuation) or the Notice of Award (for a performance report). The lines under the columns labeled Expended are to contain the actual amounts expended for each grant year that has been completed.

**FORM 4**
**PROJECT BUDGET AND EXPENDITURES**
**By Types of Services**

| | TYPES OF SERVICES | FY _____ Budgeted | FY _____ Expended | FY _____ Budgeted | FY _____ Expended |
|---|---|---|---|---|---|
| I. | **Direct Health Care Services** (Basic Health Services and Health Services for CSHCN.) | $ | $ | $ | $ |
| II. | **Enabling Services** (Transportation, Translation, Outreach, Respite Care, Health Education, Family Support Services, Purchase of Health Insurance, Case Management, and Coordination with Medicaid, WIC and Education.) | $ | $ | $ | $ |
| III. | **Population-Based Services** (Newborn Screening, Lead Screening, Immunization, Sudden Infant Death Syndrome Counseling, Oral Health, Injury Prevention, Nutrition, and Outreach/Public Education.) | $ | $ | $ | $ |
| IV. | **Infrastructure Building Services** (Needs Assessment, Evaluation, Planning, Policy Development, Coordination, Quality Assurance, Standards Development, Monitoring, Training, Applied Research, Systems of Care, and Information Systems.) | $ | $ | $ | $ |
| V. | **TOTAL** | $ | $ | $ | $ |

## INSTRUCTIONS FOR THE COMPLETION OF FORM 4
## PROJECT BUDGET AND EXPENDITURES BY TYPES OF SERVICES

Complete all required data cells for all years of the g rant. If an actual number is not available, make an estimate. Please explain all estimates in a note. Administrative dollars should be allocated to the appropriate level(s) of the pyramid on lines I, II, II or IV. If an estimate of administrative funds use is necessary, one method would be to allocate those dollars to Lines I, II, III and IV at the same percentage as program dollars are allocated to Lines I through IV.

Note: Lines I, II and II are for projects providing services. If grant funds are used to build the infrastructure for direct care delivery, enabling or population-based services, these amounts should be reported in Line IV (i.e., building data collection capacity for newborn hearing screening).

Line I Direct Health Care Services - enter the budgeted and expended amounts for the appropriate fiscal year completed and budget estimates only for all other years.

**Direct Health Care Services** are those services generally delivered one-on-one between a health professional and a patient in an office, clinic or emergency room which may include primary care physicians, registered dietitians, public health or visiting nurses, nurses certified for obstetric and pediatric primary care, medical social workers, nutritionists, dentists, sub-specialty physicians who serve children with special health care needs, audiologists, occupational therapists, physical therapists, speech and language therapists, specialty registered dietitians. Basic services include what most consider ordinary medical care, inpatient and outpatient medical services, allied health services, drugs, laboratory testing, x-ray services, dental care, and pharmaceutical products and services. State Title V programs support - by directly operating programs or by funding local providers - services such as prenatal care, child health including immunizations and treatment or referrals, school health and family planning. For CSHCN, these services include specialty and sub-specialty care for those with HIV/AIDS, hemophilia, birth defects, chronic illness, and other conditions requiring sophisticated technology, access to highly trained specialists, or an array of services not generally available in most communities.

Line II Enabling Services - enter the budgeted and expended amounts for the appropriate fiscal year completed and budget estimates only for all other years.

**Enabling Services** allow or provide for access to and the derivation of benefits from, the array of basic health care services and include such things as transportation, translation services, outreach, respite care, health education, family support services, purchase of health insurance, case management, coordination of with Medicaid, WIC and educations. These services are especially required for the low income, disadvantaged, geographically or culturally isolated, and those with special and complicated health needs. For many of these individuals, the enabling services are essential - for without them access is not possible. Enabling services most commonly provided by agencies for CSHCN include transportation, care coordination, translation services, home visiting, and family outreach. Family support activities include parent support groups, family training workshops, advocacy, nutrition and social work.

Line III Population-Based Services - enter the budgeted and expended amounts for the appropriate fiscal year completed and budget estimates only for all other years.

**Population Based Services** are preventive interventions and personal health services, developed and available for the entire MCH population of the State rather than for individuals in a one-on-one situation. Disease prevention, health promotion, and statewide outreach are major components. Common among these services are newborn screening, lead screening, immunization, Sudden Infant Death Syndrome counseling, oral health, injury prevention, nutrition and outreach/public education. These services are generally available whether the mother or child receives care in the private or public system, in a rural clinic or an HMO, and whether insured or not.

Line IV Infrastructure Building Services - enter the budgeted and expended amounts for the appropriate fiscal year completed and budget estimates only for all other years.

**Infrastructure Building Services** are the base of the MCH pyramid of health services and form its foundation. They are activities directed at improving and maintaining the health status of all women and children by providing support for development and maintenance of comprehensive health services systems and resources including development and maintenance of health services standards/guidelines, training, data and planning systems. Examples include needs assessment, evaluation, planning, policy development, coordination, quality assurance, standards development, monitoring, training, applied research, information systems and systems of care. In the development of systems of care it should be assured that the systems are family centered, community based and culturally competent.

Line V Total – Displays the total amounts for each column, budgeted for each year and expended for each year completed.

**FORM 6**
**MATERNAL & CHILD HEALTH DISCRETIONARY GRANT**
**PROJECT ABSTRACT**
**FOR FY____**

**PROJECT:**_____

**I. PROJECT IDENTIFIER INFORMATION**

1. Project Title:
2. Project Number:
3. E-mail address:

**II. BUDGET**

1. MCHB Grant Award (Line 1, Form 2) $_____
2. Unobligated Balance (Line 2, Form 2) $_____
3. Matching Funds (if applicable) (Line 3, Form 2) $_____
4. Other Project Funds (Line 4, Form 2) $_____
5. Total Project Funds (Line 5, Form 2) $_____

**III. TYPE(S) OF SERVICE PROVIDED (Choose all that apply)**

[ ] Direct Health Care Services
[ ] Enabling Services
[ ] Population-Based Services
[ ] Infrastructure Building Services

**IV. PROJECT DESCRIPTION OR EXPERIENCE TO DATE**

A. Project Description

1. Problem (in 50 words, maximum):

2. Goals and Objectives: (List up to 5 major goals and time-framed objectives per goal for the project)

Goal 1:
Objective 1:
Objective 2:
Goal 2:
Objective 1:
Objective 2:
Goal 3:
Objective 1:
Objective 2:

Goal 4:
Objective 1:
Objective 2:
Goal 5:
Objective 1:
Objective 2:

3. Activities planned to meet project goals

4. Specify the primary *Healthy People 2020* objectives(s) (up to three) which this project addresses:

a.

b.

c.

5. Coordination (List the State, local health agencies or other organizations involved in the project and their roles)

6. Evaluation (briefly describe the methods which will be used to determine whether process and outcome objectives are met)

B. Continuing Grants ONLY

1. Experience to Date (For continuing projects ONLY):

2. Website URL and annual number of hits

## V. KEY WORDS

## VI. ANNOTATION

# INSTRUCTIONS FOR THE COMPLETION OF FORM 6
# PROJECT ABSTRACT

**NOTE:** All information provided should fit into the space provided in the form. The completed form should be no more than 3 pages in length. Where information has previously been entered in forms 1 through 5, the information will automatically be transferred electronically to the appropriate place on this form.

**Section I – Project Identifier Information**

Project Title: Displays the title for the project.
Project Number: Displays the number assigned to the project (e.g., the grant number)
E-mail address: Displays the electronic mail address of the project director

**Section II – Budget -** These figures will be transferred from Form 1, Lines 1 through 5.

**Section III - Types of Services**

Indicate which type(s) of services your project provides, checking all that apply.

**Section IV – Program Description OR Current Status (DO NOT EXCEED THE SPACE PROVIDED)**

A. New Projects only are to complete the following items:
1. A brief description of the project and the problem it addresses, such as preventive and primary care services for pregnant women, mothers, and infants; preventive and primary care services for children; and services for Children with Special Health Care Needs.
2. Provide up to 5 goals of the project, in priority order. Examples are: To reduce the barriers to the delivery of care for pregnant women, to reduce the infant mortality rate for minorities and "services or system development for children with special healthcare needs." MCHB will capture annually every project's top goals in an information system for comparison, tracking, and reporting purposes; you must list at least 1 and no more than 5 goals. For each goal, list the two most important objectives. The objective must be specific (i.e., decrease incidence by 10%) and time limited (by 2005).
3. Displays the primary Healthy people 2020 goal(s) that the project addresses.
4. Describe the programs and activities used to attain the goals and objectives, and comment on innovation, cost, and other characteristics of the methodology, proposed or are being implemented. Lists with numbered items can be used in this section.
5. Describe the coordination planned and carried out, in the space provided, if applicable, with appropriate State and/or local health and other agencies in areas(s) served by the project.
6. Briefly describe the evaluation methods that will be used to assess the success of the project in attaining its goals and objectives.

B. For continuing projects ONLY:
1. Provide a brief description of the major activities and accomplishments over the past year (not to exceed 200 words).
2. Provide website and number of hits annually, if applicable.

**Section V – Key Words**

Provide up to 10 key words to describe the project, including populations served. Choose key words from the included list.

**Section VI – Annotation**

Provide a three- to five-sentence description of your project that identifies the project's purpose, the needs and problems, which are addressed, the goals and objectives of the project, the activities, which will be used to attain the goals, and the materials, which will be developed.

# FORM 7
# DISCRETIONARY GRANT PROJECT
# SUMMARY DATA

**1. Project Service Focus**

[ ] Urban/Central City [ ] Suburban [ ] Metropolitan Area (city & suburbs)
[ ] Rural [ ] Frontier [ ] Border (US-Mexico)

**2. Project Scope**

[ ] Local [ ] Multi-county [ ] State-wide
[ ] Regional [ ] National

**3. Grantee Organization Type**

[ ] State Agency
[ ] Community Government Agency
[ ] School District
[ ] University/Institution Of Higher Learning (Non-Hospital Based)
[ ] Academic Medical Center
[ ] Community-Based Non-Governmental Organization (Health Care)
[ ] Community-Based Non-Governmental Organization (Non-Health Care)
[ ] Professional Membership Organization (Individuals Constitute Its Membership)
[ ] National Organization (Other Organizations Constitute Its Membership)
[ ] National Organization (Non-Membership Based)
[ ] Independent Research/Planning/Policy Organization
[ ] Other _____

4. **Project Infrastructure Focus** (from MCH Pyramid) if applicable

[ ] Guidelines/Standards Development And Maintenance
[ ] Policies And Programs Study And Analysis
[ ] Synthesis Of Data And Information
[ ] Translation Of Data And Information For Different Audiences
[ ] Dissemination Of Information And Resources
[ ] Quality Assurance
[ ] Technical Assistance
[ ] Training
[ ] Systems Development
[ ] Other

**5. Demographic Characteristics of Project Participants**

**Indicate the service level:**

| | |
|---|---|
| ☐ **Direct Health Care Services** | ☐ **Population-Based Services** |
| ☐ **Enabling Services** | ☐ **Infrastructure Building Services** |

| | RACE (Indicate all that apply) | | | | | | | | ETHNICITY | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | American Indian or Alaska Native | Asian | Black or African American | Native Hawaiian or Other Pacific Islander | White | More than One Race | Unrecorded | Total | Hispanic or Latino | Not Hispanic or Latino | Unrecorded | Total |
| Pregnant Women (All Ages) | | | | | | | | | | | | |
| Infants <1 year | | | | | | | | | | | | |
| Children and Youth 1 to 25 years | | | | | | | | | | | | |
| CSHCN Infants <1 year | | | | | | | | | | | | |
| CSHCN Children and Youth 1 to 25 years | | | | | | | | | | | | |
| Women 25+ years | | | | | | | | | | | | |
| Men 25+ years | | | | | | | | | | | | |
| TOTALS | | | | | | | | | | | | |

**6. Clients' Primary Language(s)**

_____
_____
_____

**7. Resource/TA and Training Centers ONLY**

Answer all that apply.

a. Characteristics of Primary Intended Audience(s)

[ ] Policy Makers/Public Servants
[ ] Consumers
[ ] Providers/Professionals

b. Number of Requests Received/Answered: ___/____
c. Number of Continuing Education credits provided: _____
d. Number of Individuals/Participants Reached: _____
e. Number of Organizations Assisted: _____
f. Major Type of TA or Training Provided:

[ ] continuing education courses,
[ ] workshops,
[ ] on-site assistance,
[ ] distance learning classes
[ ] other

# INSTRUCTIONS FOR THE COMPLETION OF FORM 7
# PROJECT SUMMARY

**Section 1 – Project Service Focus**
Select all that apply

**Section 2 – Project Scope**
Choose the one that best applies to your project.

**Section 3 – Grantee Organization Type**
Choose the one that best applies to your organization.

**Section 4 – Project Infrastructure Focus**
If applicable, choose all that apply.

**Section 5 – Demographic Characteristics of Project Participants**
Indicate the service level for the grant program. Multiple selections may be made. Please fill in each of the cells as appropriate.

**Direct Health Care Services** are those services generally delivered one-on-one between a health professional and a patient in an office, clinic or emergency room which may include primary care physicians, registered dietitians, public health or visiting nurses, nurses certified for obstetric and pediatric primary care, medical social workers, nutritionists, dentists, sub-specialty physicians who serve children with special health care needs, audiologists, occupational therapists, physical therapists, speech and language therapists, specialty registered dietitians. Basic services include what most consider ordinary medical care, inpatient and outpatient medical services, allied health services, drugs, laboratory testing, x-ray services, dental care, and pharmaceutical products and services. State Title V programs support - by directly operating programs or by funding local providers - services such as prenatal care, child health including immunizations and treatment or referrals, school health and family planning. For CSHCN, these services include specialty and sub-specialty care for those with HIV/AIDS, hemophilia, birth defects, chronic illness, and other conditions requiring sophisticated technology, access to highly trained specialists, or an array of services not generally available in most communities.

**Enabling Services** allow or provide for access to and the derivation of benefits from, the array of basic health care services and include such things as transportation, translation services, outreach, respite care, health education, family support services, purchase of health insurance, case management, coordination of with Medicaid, WIC and educations. These services are especially required for the low income, disadvantaged, geographically or culturally isolated, and those with special and complicated health needs. For many of these individuals, the enabling services are essential - for without them access is not possible. Enabling services most commonly provided by agencies for CSHCN include transportation, care coordination, translation services, home visiting, and family outreach. Family support activities include parent support groups, family training workshops, advocacy, nutrition and social work.

**Population Based Services** are preventive interventions and personal health services, developed and available for the entire MCH population of the State rather than for individuals in a one-on-one situation. Disease prevention, health promotion, and statewide outreach are major components. Common among these services are newborn screening, lead screening, immunization, Sudden Infant Death Syndrome counseling, oral health, injury prevention, nutrition and outreach/public education. These services are generally available whether the mother or child receives care in the private or public system, in a rural clinic or an HMO, and whether insured or not.

**Infrastructure Building Services** are the base of the MCH pyramid of health services and form its foundation. They are activities directed at improving and maintaining the health status of all women and children by providing support for development and maintenance of comprehensive health services systems and resources including development and maintenance of health services standards/guidelines, training, data and planning systems. Examples include needs assessment, evaluation, planning, policy development, coordination, quality assurance, standards development, monitoring, training, applied research, information systems and systems of care. In the development of systems of care it should be assured that the systems are family centered, community based and culturally competent.

**Section 6 – Clients Primary Language(s)**
Indicate which languages your clients speak as their primary language, other than English, for the data provided in Section 6. List up to three languages.

**Section 7 – Resource/TA and Training Centers (Only)**
Answer all that apply.

| | |
|---|---|
| **07 PERFORMANCE MEASURE**<br><br>**Goal 1: Provide National Leadership for MCHB (Promote family participation in care)**<br>**Level: Grantee**<br>**Category: Family/Youth/Consumer Participation** | The degree to which MCHB-funded programs ensure family, youth, and consumer participation in program and policy activities. |
| **GOAL** | To increase family/youth/consumer participation in MCHB programs. |
| **MEASURE** | The degree to which MCHB-funded programs ensure family/youth/consumer participation in program and policy activities. |
| **DEFINITION** | Attached is a checklist of eight elements that demonstrate family participation, including an emphasis on family-professional partnerships and building leadership opportunities for families and consumers in MCHB programs. Please check the degree to which the elements have been implemented. |
| **HEALTHY PEOPLE 2010 OBJECTIVE** | Related to Objective 16.23. Increase the proportion of Territories and States that have service systems for Children with Special Health Care Needs to 100 percent. |
| **DATA SOURCE(S) AND ISSUES** | Attached data collection form is to be completed by grantees. |
| **SIGNIFICANCE** | Over the last decade, policy makers and program administrators have emphasized the central role of families and other consumers as advisors and participants in policy-making activities. In accordance with this philosophy, MCHB is facilitating such partnerships at the local, State and national levels.<br><br>Family/professional partnerships have been: incorporated into the MCHB Block Grant Application, the MCHB strategic plan. Family/professional partnerships are a requirement in the Omnibus Budget Reconciliation Act of 1989 (OBRA '89) and part of the legislative mandate that health programs supported by Maternal and Child Health Bureau (MCHB) Children with Special Health Care Needs (CSHCN) provide and promote family centered, community-based, coordinated care. |

**DATA COLLECTION FORM FOR DETAIL SHEET #07**

Using a scale of 0-3, please rate the degree to which the grant program has included families, youth, and consumers into their program and planning activities. Please use the space provided for notes to describe activities related to each element and clarify reasons for score.

| 0 | 1 | 2 | 3 | Element |
|---|---|---|---|---|
| | | | | 1. Family members/youth/consumers participate in the planning, implementation and evaluation of the program's activities at all levels, including strategic planning, program planning, materials development, program activities, and performance measure reporting. |
| | | | | 2. Culturally diverse family members/youth/consumers facilitate the program's ability to meet the needs of the populations served. |
| | | | | 3. Family members/youth/consumers are offered training, mentoring, and opportunities to lead advisory committees or task forces. |
| | | | | 4. Family members/youth/consumers who participate in the program are compensated for their time and expenses. |
| | | | | 5. Family members/youth/consumers participate on advisory committees or task forces to guide program activities. |
| | | | | 6. Feedback on policies and programs is obtained from families/youth/consumers through focus groups, feedback surveys, and other mechanisms as part of the project's continuous quality improvement efforts. |
| | | | | 7. Family members/youth/consumers work with their professional partners to provide training (pre-service, in-service and professional development) to MCH/CSHCN staff and providers. |
| | | | | 8. Family /youth/consumers provide their perspective to the program as paid staff or consultants. |

0=Not Met
1=Partially Met
2=Mostly Met
3=Completely Met

Total the numbers in the boxes (possible 0-24 score) _____

**NOTES/COMMENTS:**

| | |
|---|---|
| **08 PERFORMANCE MEASURE**<br><br>**Goal 1: Provide National Leadership for Maternal and Child Health (Provide both graduate level and continuing education training to assure interdisciplinary MCH public health leadership nationwide)**<br>**Level: Grantee**<br>**Category: Training** | The percentage of graduates of MCHB long-term training programs that demonstrate field leadership after graduation. |
| **GOAL** | To increase the percentage of graduates of long-term training programs that demonstrate field leadership five years after graduation. |
| **MEASURE** | The percentage of graduates of MCHB long-term training programs that demonstrate field leadership after graduation. |
| **DEFINITION** | Attached is a checklist of four elements that demonstrate field leadership. For each element, identify the number of graduates of MCHB long-term training programs that demonstrate field leadership five years after graduation. Please keep the completed checklist attached.<br><br>"Field leadership" refers to but is not limited to providing MCH leadership within the clinical, advocacy, academic, research, public health, public policy or governmental realms. Refer to attachment for complete definition.<br><br>Cohort is defined as those who graduate in a certain project period. Data form for each cohort year will be collected five years following graduation. |
| **HEALTHY PEOPLE 2010 OBJECTIVE** | Related to Objective 1.7: (Developmental) Increase the proportion of schools of medicine, schools of nursing, and other health professional training schools whose basic curriculum for health care providers includes the core competencies in health promotion and disease prevention.<br><br>Related to Objective 23.8: (Developmental) Increase the proportion of Federal, Tribal, State, and local agencies that incorporate specific competencies in the essential public health services into personnel systems. |
| **DATA SOURCE(S) AND ISSUES** | Attached data collection form to be completed by grantees. |
| **SIGNIFICANCE** | An MCHB trained workforce is a vital participant in clinical, administrative, policy, public health and various other arenas. MCHB long-term training programs assist in developing a public health workforce that addresses MCH concerns and fosters field leadership in the MCH arena. |

**DATA COLLECTION FORM FOR DETAIL SHEET #08**

A. The total number of graduates, five years following completion of program _____

B. The total number of graduates lost to follow up _____

C. The total number of respondents (A-B) _____

D. Number of respondents demonstrating MCH leadership in **at least one** of the following areas below _____

E. Percent of respondents demonstrating MCH leadership in at least one of the following areas below _____

Please use the notes field to detail data sources and year of data used.
(Individual respondents may have leadership activities in multiple areas below)

1. Number of trainees that have participated in **academic** leadership activities _____

- Disseminated information on MCH Issues (e.g., Peer-reviewed publications, key presentations, training manuals, issue briefs, best practices documents, standards of care)
- Conducted research or quality improvement on MCH issues
- Provided consultation or technical assistance in MCH areas
- Taught/mentored in my discipline or other MCH related field
- Served as a reviewer (e.g., for a journal, conference abstracts, grant, quality assurance process)
- Procured grant and other funding in MCH areas
- Conducted strategic planning or program evaluation

2. Number of trainees that have participated in **clinical** leadership activities _____

- Participated as a group leader, initiator, key contributor or in a position of influence/authority on any of the following: committees of State, national, or local organizations; task forces; community boards; advocacy groups; research societies; professional societies; etc.
- Served in a clinical position of influence (e.g. director, senior therapist, team leader, etc
- Taught/mentored in my discipline or other MCH related field
- Conducted research or quality improvement on MCH issues
- Disseminated information on MCH Issues (e.g., Peer-reviewed publications, key presentations, training manuals, issue briefs, best practices documents, standards of care)
- Served as a reviewer (e.g., for a journal, conference abstracts, grant, quality assurance process)

3. Number of trainees that have participated in **public health practice** leadership activities _____

- Provided consultation, technical assistance, or training in MCH areas
- Procured grant and other funding in MCH areas
- Conducted strategic planning or program evaluation
- Conducted research or quality improvement on MCH issues
- Served as a reviewer (e.g., for a journal, conference abstracts, grant, quality assurance process)
- Participated in public policy development activities (e.g., Participated in community engagement or coalition building efforts, written policy or guidelines, influenced MCH related legislation (provided testimony, educated legislators, etc)

4. Number of trainees that have participated in **public policy & advocacy** leadership activities _____

- Participated in public policy development activities (e.g., participated in community engagement or coalition building efforts, written policy or guidelines, influenced MCH related legislation, provided testimony, educated legislators)
- Participated on any of the following as a group leader, initiator, key contributor, or in a position of influence/authority: committees of State, national, or local organizations; task forces; community boards; advocacy groups; research societies; professional societies; etc.
- Disseminated information on MCH public policy Issues (e.g., Peer-reviewed publications, key presentations, training manuals, issue briefs, best practices documents, standards of care)

**NOTES/COMMENTS:**

| | |
|---|---|
| **09 PERFORMANCE MEASURE**<br><br>**Goal 2: Eliminate Health Barriers and Disparities (Train an MCH Workforce that is culturally competent and reflects an increasingly diverse population)**<br>**Level: Grantee**<br>**Category: Training** | The percentage of participants in MCHB long-term training programs who are from underrepresented racial and ethnic groups. |
| **GOAL** | To increase the percentage of trainees participating in MCHB long-term training programs who are from underrepresented racial and ethnic groups. |
| **MEASURE** | The percentage of participants in MCHB long-term training programs who are from underrepresented racial and ethnic groups. |
| **DEFINITION** | **Numerator**:<br><br>Total number of long-term trainees (≥ 300 contact hours) participating in MCHB training programs reported to be from underrepresented racial and ethnic groups. (Include MCHB-supported and non-supported trainees.)<br><br>**Denominator**:<br><br>Total number of long-term trainees (≥ 300 contact hours) participating in MCHB training programs. (Include MCHB-supported and non-supported trainees.)<br><br>**Units**: 100 **Text**: Percentage<br><br>The definition of "underrepresented racial and ethnic groups" is based on the categories from the U.S. Census. |
| **HEALTHY PEOPLE 2010 OBJECTIVE** | Related to Objective 1.8: In the health professions, allied and associated health professions, and the nursing field, increase the proportion of all degrees awarded to members of underrepresented racial and ethnic groups. |
| **DATA SOURCE(S) AND ISSUES** | Data will be collected annually from grantees about their trainees.<br>MCHB does not maintain a master list of all trainees who are supported by MCHB long-term training programs.<br><br>References supporting Workforce Diversity:<br>• In the Nation's Compelling Interest: Ensuring Diversity in the Healthcare Workforce (2004). Institute of Medicine. |

- Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care (2002). Institute of Medicine.

**SIGNIFICANCE**

HRSA's MCHB places special emphasis on improving service delivery to women, children and youth from communities with limited access to comprehensive care. Training a diverse group of professionals is necessary in order to provide a diverse public health workforce to meet the needs of the changing demographics of the U.S. and to ensure access to culturally competent and effective services. This performance measure provides the necessary data to report on HRSA's initiatives to reduce health disparities.

**DATA COLLECTION FORM FOR DETAIL SHEET #09**

Report on the percentage of long-term trainees (≥300 contact hours) who are from any underrepresented racial/ethnic group (i.e., Hispanic or Latino, American Indian or Alaskan Native, Asian, Black or African-American, Native Hawaiian or Pacific Islander, two or more race (OMB). Please use the space provided for notes to detail the data source and year of data used.

- Report on all long-term trainees (≥ 300 contact hours) including MCHB-funded and non MCHB-funded trainees
- Report race and ethnicity separately
- Trainees who select multiple ethnicities should be counted once
- Grantee reported numerators and denominator will be used to calculate percentages

Total number of long-term trainees (≥ 300 contact hours) participating in the training program. (Include MCHB-supported and non-supported trainees.) _____

**NOTES/ COMMENTS**:

**Ethnic Categories**

Number of long-term training participants who are Hispanic or Latino (Ethnicity) _____

**Racial Categories**

Number of long-term trainees who are American Indian or Alaskan Native _____

Number of long-term trainees who are of Asian descent _____

Number of long-term trainees who are Black or African-American _____

Number of long-term trainees who are Native Hawaiian or Pacific Islanders _____

Number of long-term trainees who are two or more races _____

| | |
|---|---|
| **10 PERFORMANCE MEASURE**<br><br>**Goal 2: Eliminate Health Barriers & Disparities (Develop and promote health services and systems of care designed to eliminate disparities and barriers across MCH populations)**<br>**Level: Grantee**<br>**Category: Cultural Competence** | The degree to which MCHB-funded programs have incorporated cultural and linguistic competence elements into their policies, guidelines, contracts and training. |
| **GOAL** | To increase the number of MCHB-funded programs that have integrated cultural and linguistic competence into their policies, guidelines, contracts and training. |
| **MEASURE** | The degree to which MCHB-funded programs have incorporated cultural and linguistic competence elements into their policies, guidelines, contracts and training. |
| **DEFINITION** | Attached is a checklist of 15 elements that demonstrate cultural and linguistic competence. Please check the degree to which the elements have been implemented. The answer scale for the entire measure is 0-45. Please keep the completed checklist attached.<br><br>Cultural and linguistic competence is a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations. 'Culture' refers to integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups. 'Competence' implies having the capacity to function effectively as an individual and an organization within the context of the cultural beliefs, behaviors, and needs presented by consumers and their communities. (Adapted from Cross, 1989; sited from DHHS Office of Minority Health--http://www.omhrc.gov/templates/browse.aspx?lvl=2&lvlid=11)<br><br>Linguistic competence is the capacity of an organization and its personnel to communicate effectively, and convey information in a manner that is easily understood by diverse audiences including persons of limited English proficiency, those who have low literacy skills or are not literate, and individuals with disabilities. Linguistic competence requires organizational and provider capacity to respond effectively to the health literacy needs of populations served. The organization must have policy, structures, practices, procedures, and dedicated resources to support this capacity. (Goode, T. and W. Jones, |

2004. National Center for Cultural Competence; http://www.nccccurricula.info/linguisticcompetence.html)

Cultural and linguistic competence is a process that occurs along a developmental continuum. A culturally and linguistically competent program is characterized by elements including the following: written strategies for advancing cultural competence; cultural and linguistic competence policies and practices; cultural and linguistic competence knowledge and skills building efforts; research data on populations served according to racial, ethnic, and linguistic groupings; participation of community and family members of diverse cultures in all aspects of the program; faculty and other instructors are racially and ethnically diverse; faculty and staff participate in professional development activities related to cultural and linguistic competence; and periodic assessment of trainees' progress in developing cultural and linguistic competence.

**HEALTHY PEOPLE 2010 OBJECTIVE**

Related to the following HP2010 Objectives:

16.23: Increase the proportion of States and jurisdictions that have service systems for children with or at risk for chronic and disabling conditions as required by Public Law 101-239.

23.9: (Developmental) Increase the proportion of schools for public health workers that integrate into their curricula specific content to develop competence in the essential public health services.

23.11:(Developmental) Increase the proportion of State and local public health agencies that meet national performance standards for essential public health services.

23.15: (Developmental) Increase the proportion of Federal, Tribal, State, and local jurisdictions that review and evaluate the extent to which their statutes, ordinances, and bylaws assure the delivery of essential public health services.

**DATA SOURCE(S) AND ISSUES**

Attached data collection form is to be completed by grantees.
There is no existing national data source to measure the extent to which MCHB supported programs have incorporated cultural competence elements into their policies, guidelines, contracts and training.

**SIGNIFICANCE**

Over the last decade, researchers and policymakers have emphasized the central influence of cultural values and cultural/linguistic barriers: health seeking behavior, access to care, and racial and

ethnic disparities. In accordance with these concerns, cultural competence objectives have been: (1) incorporated into the MCHB strategic plan; and (2) in guidance materials related to the Omnibus Budget Reconciliation Act of 1989 (OBRA '89), which is the legislative mandate that health programs supported by MCHB Children with Special Health Care Needs (CSHCN) provide and promote family centered, community-based, coordinated care.

**DATA COLLECTION FORM FOR DETAIL SHEET #10**

Using a scale of 0-3, please rate the degree to which your grant program has incorporated the following cultural/linguistic competence elements into your policies, guidelines, contracts and training.

Please use the space provided for notes to describe activities related to each element, detail data sources and year of data used to develop score, clarify any reasons for score, and or explain the applicability of elements to program.

| 0 | 1 | 2 | 3 | Element |
|---|---|---|---|---|
| | | | | 1. Strategies for advancing cultural and linguistic competence are integrated into your program's written plan(s) (e.g., grant application, recruiting plan, placement procedures, monitoring and evaluation plan, human resources, formal agreements, etc.). |
| | | | | 2. There are structures, resources, and practices within your program to advance and sustain cultural and linguistic competence. |
| | | | | 3. Cultural and linguistic competence knowledge and skills building are included in training aspects of your program. |
| | | | | 4. Research or program information gathering includes the collection and analysis of data on populations served according to racial, ethnic, and linguistic groupings, where appropriate. |
| | | | | 5. Community and family members from diverse cultural groups are partners in planning your program. |
| | | | | 6. Community and family members from diverse cultural groups are partners in the delivery of your program. |
| | | | | 7. Community and family members from diverse cultural groups are partners in evaluation of your program. |
| | | | | 8. Staff and faculty reflect cultural and linguistic diversity of the significant populations served. |
| | | | | 9. Staff and faculty participate in professional development activities to promote their cultural and linguistic competence. |
| | | | | 10. A process is in place to assess the progress of your program participants in developing cultural and linguistic competence. |

0 = Not Met
1 = Partially Met
2 = Mostly Met
3 = Completely Met

Total the numbers in the boxes (possible 0-30 score) _____

**NOTES/COMMENTS***:*

| | |
|---|---|
| **59 PERFORMANCE MEASURE** | The degree to which a training program collaborates with State Title V agencies, other MCH or MCH-related programs. |
| **GOAL** | To assure that a training program has collaborative interactions related to training, technical assistance, continuing education, and other capacity-building services with relevant national, state and local programs, agencies and organizations. |
| **MEASURE** | The degree to which a training program collaborates with State Title V agencies, other MCH or MCH-related programs and other professional organizations. |
| **DEFINITION** | Attached is a list of the 6 elements that describe activities carried out by training programs for or in collaboration with State Title V and other agencies on a scale of 0 to 1. If a value of '1' is selected, provide the number of activities for the element. The total score for this measure will be determined by the sum of those elements noted as '1.' |
| **HEALTHY PEOPLE 2010 OBJECTIVE** | 1-7. Increase the proportion of schools of medicine, schools of nursing, and other health professional training schools whose basic curriculum for health care providers includes the core competencies in health promotion and disease prevention.<br>7-2. Increase the proportion of middle, junior high, and senior high schools that provide school health education to prevent health problems…<br>7-11. Increase the proportion of local health departments that have established culturally appropriate and linguistically competent community health promotion and disease prevention programs.<br>23-8, 23-10. Increase the proportion of Federal, Tribal, State, and local agencies that incorporate specific competencies and provide continuing education to develop competence in the essential public health services. |
| **DATA SOURCES AND ISSUES** | The training program completes the attached table which describes the categories of collaborative activity. |

**SIGNIFICANCE**

As a SPRANS, a training program enhances the Title V State block grants that support the MCHB goal to promote comprehensive, coordinated, family-centered, and culturally-sensitive systems of health care that serve the diverse needs of all families within their own communities. Interactive collaboration between a training program and Federal, Tribal, State and local agencies dedicated to improving the health of MCH populations will increase active involvement of many disciplines across public and private sectors and increase the likelihood of success in meeting the goals of relevant stakeholders.

This measure will document a training program's abilities to:

1) collaborate with State Title V and other agencies (at a systems level) to support achievement of the MCHB Strategic Goals and CSHCN Healthy People 2010 action plan;
2) make the needs of MCH populations more visible to decision-makers and can help states achieve best practice standards for their systems of care;
3) reinforce the importance of the value added to LEAH program dollars in supporting faculty leaders to work at all levels of systems change; and
4) internally use this data to assure a full scope of these program elements in all regions.

**DATA COLLECTION FORM FOR DETAIL SHEET PM #59**

Indicate the degree to which your training program collaborates with State Title V (MCH) agencies and other MCH or MCH-related programs using the following values:

0= The training program does not collaborate on this element.
1=The training program does collaborate on this element.

If your program does collaborate, provide the total number of activities for the element.

| Element | 0 | 1 | Total Number of Activities |
|---|---|---|---|
| 1. **Service**<br>Examples might include: Clinics run by the training program and/ or in collaboration with other agencies | | | |
| 2. **Training**<br>Examples might include: Training in *Bright Futures…*; Workshops related to adolescent health practice; and Community-based practices. It would not include clinical supervision of long-term trainees. | | | |
| 3. **Continuing Education**<br>Examples might include: Conferences; Distance learning; and Computer-based educational experiences. It would not include formal classes or seminars for long-term trainees. | | | |
| 4. **Technical Assistance**<br>Examples might include: Conducting needs assessments with State programs; policy development; grant writing assistance; identifying best-practices; and leading collaborative groups. It would not include conducting needs assessments of consumers of the training program services. | | | |
| 5. **Product Development**<br>Examples might include: Collaborataive development of journal articles and training or informational videos. | | | |
| 6. **Research**<br>Examples might include: Collaborative submission of research grants, research teams that include Title V or other MCH-program staff and the training program's faculty. | | | |

**Total Score (possible 0-6 score) _____**
**Total Number of Collaborative Activities _____**

| | |
|---|---|
| **60 PERFORMANCE MEASURE** | The percent of long-term trainees who, at 1, 5 and 10 years post training, work in an interdisciplinary manner to serve the MCH population (e.g., individuals with disabilities and their families, adolescents and their families, etc.). |
| **GOAL** | To increase the percent of long-term trainees who, upon completing their training, work in an interdisciplinary manner to serve the MCH population. |
| **MEASURE** | The percent of long-term trainees who, at 1, 5 and 10 years post training work in an interdisciplinary manner to serve the MCH population. |
| **DEFINITION** | **Numerator:** The number of trainees indicating that they continue to work in an interdisciplinary setting serving the MCH population.<br>**Denominator:** The total number of trainees responding to the survey<br>**Units:** 100 **Text:** Percent<br>In addition, data on the total number of the trainees and the number of non-respondents for each year will be collected.<br><br>Long-term trainees are defined as those who have completed a long-term (300+ hours) leadership training program, including those who received MCH funds and those who did not. |
| **HEALTHY PEOPLE 2010 OBJECTIVE** | 1-7: Increase proportion of schools of medicine, schools of nursing, and other health professional training schools whose basic curriculum for health care providers includes the core competencies in health promotion and disease prevention.<br>16-23: Increase the proportion of Territories and States that have service systems for children with special health care needs.<br>23-9: Increase the proportion of schools for public health workers that integrate into their curricula specific content to develop competence in the essential public health services. |
| **DATA SOURCE(S) AND ISSUES** | The trainee follow-up survey is used to collect these data. |
| **SIGNIFICANCE** | Leadership education is a complex interdisciplinary field that must meet the needs of MCH populations. This measure addresses one of a training program's core values and its unique role to prepare professionals for comprehensive systems of care. By providing interdisciplinary coordinated care, training programs help to ensure that all MCH populations receive the most comprehensive care that takes into account the complete and unique needs of the individuals and their families. |

| | |
|---|---|
| **64 PERFORMANCE MEASURE** | The degree to which the Leadership Education in Adolescent Health program incorporates adolescents and parents from diverse ethnic and cultural backgrounds as advisors and participants in program activities. |
| **GOAL** | To increase appropriate involvement of adolescents and parents as consumers of Leadership Education in Adolescent Health program activities. |
| **MEASURE** | The degree to which adolescents and parents are incorporated as consumers of Leadership Education in Adolescent Health program activities. |
| **DEFINITION** | Attached is a checklist of 4 elements that document adolescent and parent participation. Respondents will note the presence or absence of this participation on a scale of 0-1 for a total possible score of 4. |
| **HEALTHY PEOPLE 2010 OBJECTIVE** | 11-3. (Developmental) Increase the proportion of health communication activities that include research and evaluation.<br><br>11.6 (Developmental) Increase the proportion of persons who report that their health care providers have satisfactory communication skills. |
| **DATA SOURCE(S) AND DATA ISSUES** | Grantees report using a data collection form. These data may be collected with the Leadership Education in Adolescent Health self-assessment activities. Participation should be defined to permit assessment of youth and young adult involvement. |
| **SIGNIFICANCE** | Over the last decade, policy makers and program administrators have emphasized the central role of consumer of health services as advisors and participants in program activities. Satisfaction with health care is related to satisfaction with the quality of the communication with health providers. In accordance with this philosophy, Leadership Education in Adolescent Health facilitates such partnerships and believes that consumers (adolescents and parents) from diverse backgrounds have important roles in the training of future leaders in adolescent health care delivery systems. |

**DATA COLLECTION FORM FOR DETAIL SHEET #64**

**Indicate the degree to which your training program has the active involvement of adolescents and parents in your program and planning activities using the following values:**

**0 = The training program does not have active involvement of adolescents and parents in your program and planning activities.**
**1 = The training program does have active involvement of adolescents and parents in your program and planning activities.**

| Element | 0 | 1 |
|---|---|---|
| 1. Adolescents from diverse ethnic backgrounds and cultures participate in an advisory capacity. | | |
| 2. Parents of adolescents from diverse ethnic backgrounds and cultures participate in an advisory capacity. | | |
| 3. Adolescents from diverse ethnic backgrounds and cultures participate in the planning, implementation and evaluation of program activities related to adolescents as consumer. | | |
| 4. Parents of adolescents from diverse ethnic backgrounds and cultures participate in the planning, implementation and evaluation of program activities related to parents as consumers. | | |

**Total Score (possible 0-24 score) _____**

| | |
|---|---|
| **84 PERFORMANCE MEASURE**<br><br>**Goal 2: Eliminate Health Barriers and Disparities**<br>**Level: Grantee**<br>**Category: Training** | The percent of long-term training graduates who are engaged in work related to MCH populations |
| **GOAL** | To increase the percent of graduates of MCH long-term training programs who are engaged in work related to MCH populations. |
| **MEASURE** | The percent of long-term training graduates who are engaged in work related to MCH populations. |
| **DEFINITION** | **Numerator**:<br><br>Number of trainees reporting they are engaged in work related to MCH populations<br><br>**Denominator**:<br><br>The total number of trainees responding to the survey<br><br>**Units**: 100 **Text**: Percent<br><br>Long-term trainees are defined as those who have completed a long-term (greater than or equal to 300 contact hours) leadership training program, including those who received MCH funds and those who did not.<br><br>**MCH Populations**: Includes all of the Nation's women, infants, children, adolescents, and their families, including and children with special health care needs (MCHB Strategic Plan: FYs 2003-2007) |
| **HEALTHY PEOPLE 2010 OBJECTIVE** | Related to Goal 1: Improve access to comprehensive, high-quality health care services (Objectives 1.1-1.16).<br><br>Related to Goal 7 – Educational and community-based programs: Increase the quality, availability and effectiveness of educational and community-based programs designed to prevent disease and improve health and quality of life. Specific objectives: 7-7 through 7-11.<br><br>Related to Goal 23 – Public Health Infrastructure: Ensure that Federal, Tribal, State, and local health agencies have the infrastructure to provide essential public health services effectively. Specific objectives: 23-8 through 23-10 |
| **DATA SOURCE(S) AND ISSUES** | A revised trainee follow-up survey that incorporates |

the new form for collecting data on the involvement of MCH training program graduates in work related to MCH populations will be used to collect these data.

Data Sources Related to Training and Work Settings/Populations:

Rittenhouse Diane R, George E. Fryer, Robert L. Pillips et al. Impact of Title Vii Training Programs on Community Health Center Staffing and National Health Service Corps Participation. *Ann Fam Med* 2008;6:397-405. DOI: 10.1370/afm.885.

Karen E. Hauer, Steven J. Durning, Walter N. Kernan, et al. Factors Associated With Medical Students' Career
Choices Regarding Internal Medicine *JAMA*. 2008;300(10):1154-1164
(doi:10.1001/jama.300.10.1154)

**SIGNIFICANCE**

HRSA's MCHB places special emphasis on improving service delivery to women, children and youth from communities with limited access to comprehensive care.

**DATA COLLECTION FORM FOR DETAIL SHEET # 84**

Long-term training graduates who report working with **the maternal and child health population** (i.e., women, infants, children, adolescents, and their families, including and children with special health care needs) 5 years after completing their training program.

*NOTE: If the individual works with more than one of these groups only count them once.*

A. The total number of graduates, 5 years following completion of program _____

B. The total number of graduates lost to follow-up _____

C. The total number of respondents (A-B) = denominator _____

D. Number of respondents who report working with an MCH population _____

E. Percent of respondents who report working with an MCH population _____

Use the notes field to detail data source used and information that provides significant context for the data.

| | |
|---|---|
| **85 PERFORMANCE MEASURE**<br><br>**Goal 5: Generate, translate, and integrate new knowledge to enhance MCH training, inform policy, and improve health outcomes Level: Grantee**<br>**Category: Training** | The degree to which MCH long-term training grantees engage in policy development, implementation, and evaluation. |
| **GOAL** | To increase the number of MCH long-term training programs that actively promote the transfer and utilization of MCH knowledge and research to the policy arena through the work of faculty, trainees, alumni, and collaboration with Title V. |
| **MEASURE** | The degree to which MCH long-term training grantees engage in policy development, implementation, and evaluation. |
| **DEFINITION** | Attached is a checklist of six elements that demonstrate policy engagement. Please check the degree to which the elements have been implemented. The answer scale is 0-18. Please keep the completed checklist attached.<br><br>Policy development, implementation and evaluation in the context of MCH training programs relates to the process of translating research to policy and training for leadership in the core public health function of policy development.<br><br>Actively – mutual commitment to policy-related projects or objectives within the past 12 months. |
| **HEALTHY PEOPLE 2010 OBJECTIVE** | Related to Goal 23: Public Health Infrastructure "Ensure that Federal, tribal, State, and local health agencies have the infrastructure to provide essential public health services effectively.<br><br>Related to Objective 23.9: (Developmental) Increase the proportion of schools for public health workers that integrate into their curricula specific content to develop competence in the essential public health services.<br><br>Related to Objective 23.17: (Developmental) Increase the proportion of Federal, Tribal, State, and local public health agencies that conduct or collaborate on population-based prevention research. |
| **DATA SOURCE(S) AND ISSUES** | • Attached data collection form to be completed by grantee.<br>• Data will be collected from competitive and continuation applications as part of the grant application process and annual reports. The elements of training program engagement in policy |

development, implementation, and evaluation need to be operationally defined with progress noted on the attached draft checklist with an example described more fully in the narrative application.

**SIGNIFICANCE**

Policy development is one of the three core functions of public health as defined in 1988 by the Institute of Medicine in *The Future of Public Health* (National Academy Press, Washington DC).

In this landmark report by the IOM, the committee recommends that "*every public health agency exercise its responsibility to serve the public interest in the development of comprehensive public health policies by promoting use of the scientific knowledge base in decision-making about public health and by leading in developing public health policy."* Academic institutions such as schools of public health and research universities have the dual responsibility to develop knowledge and to produce well-trained professional practitioners.

This national performance measure relates directly to Goal 5 of the National MCHB Training Strategic Plan to "generate, translate, and integrate new knowledge to enhance MCH training, inform policy, and improve health outcomes".

**DATA COLLECTION FORM FOR DETAIL SHEET #85**

Using a scale of 0-3, please rate the degree to which your training program has addressed the following policy development, implementation and evaluation elements.

| 0 | 1 | 2 | 3 | Element |
|---|---|---|---|---|
| | | | | 1. Provide multiple didactic opportunities for training on policy development and advocacy to increase understanding of how the policy process works at the federal, state and local levels. |
| | | | | 2. Provide multiple opportunities within the practicum/field/clinical experience portion of the training curriculum for knowledge and skills building in policy development, implementation and evaluation. |
| | | | | 3. A process is in place for assessing the policy knowledge and skills of trainees. |
| | | | | 4. Research findings are disseminated and effectively communicated directly to public health agency leaders and policy officials with attention to how these findings add to the evidence-base for policy decisions and resource allocation. |
| | | | | 5. Faculty or staff contributes to the development of guidelines, regulations, legislation or other public policy at the local, state, and/or national level. |
| | | | | 6. Participate in developing and strengthening local, state, and/or national MCH advocacy networks and initiatives. Examples include MCH coalitions, teen pregnancy prevention initiatives, family advocacy groups, or advocacy groups in professional organizations. |

0=Not Met
1=Partially Met
2=Mostly Met
3=Completely Met
Total the numbers in the boxes (possible 0-18 score) _____

# MCH TRAINING AND EDUCATION PROGRAMS DATA FORM

## Faculty and Staff Information

List all personnel (faculty, staff, and others) contributing[9] to your training project, including those listed in the budget form and budget narrative and others that your program considers to have a central and ongoing role in the leadership training program whether they are supported or not supported by the grant.

Personnel (Do not list trainees)

| **Name** | **Ethnicity** (Hispanic or Not Hispanic) | **Race** (American Indian or Alaska Native, Asian, Black or African American, Native Hawaiian or Other Pacific Islander, White, More than One Race, Unrecorded) | **Gender** (Male or Female) | **Discipline** | **Year Hired in MCH Leadership Training Program** | **Former MCHB Trainee?** (Yes/No) |
|---|---|---|---|---|---|---|
| **Faculty** | | | | | | |
| | | | | | | |
| **Staff** | | | | | | |
| | | | | | | |
| **Other** | | | | | | |
| | | | | | | |

[9] A 'central' role refers to those that regularly participate in on-going training activities such as acting as a preceptors; teaching core courses; and participating in other core leadership training activities that would be documented in the progress reports.

**Trainee Information (Long–term Trainees Only)**

Definition: Long-term trainees (those with greater than or equal to 300 contact hours within the training program) benefiting from the training grant (both supported and non-supported trainees).

Total Number of long-term trainees participating in the training program* _____
Name
Ethnicity
Race
Gender
Address (For supported trainees ONLY)
    City
    State
    Country
Discipline(s) upon Entrance to the Program
Degree(s)
Position at Admission (position title and setting)
Degree Program in which enrolled
Received financial MCH support? [ ] Yes [ ] No Amount: $_____
Type: [ ] Undergraduate [ ] Pre-doctoral [ ] Post-doctoral
    [ ] Part-time student [ ] Full-time student

Epidemiology training grants ONLY
Length of time receiving support: _____
Research Topic or Title_____

*All trainees participating in the program, whether receiving MCH stipend support or not.

**Former Trainee Information (Long-term trainees and former trainees of the Pipeline and Certificate Programs)**

**The following information is to be provided for each long-term trainee who completed the Training Program 5 years prior to the current reporting year.** Definition of Former Trainee = Grant supported trainees who completed the program 5 years ago

☐ Project does not have any trainees who have completed the Training Program 5 years prior to current reporting year.

| Name | Year Graduated | Degree(s) Earned with MCH support (if applicable) | Was University able to contact the trainee? | City of Residence | State of Residence | Country of Residence | Current Employment Setting *(see pick list below*)* | Working in Public Health organization or agency (including Title V)? (Yes/No) | Working in MCH? (Yes/No) | Working with underserved populations or vulnerable groups**? (Yes/No) | Met criteria for Leadership in PM 08? (Yes/No) |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | | |
| | | | | | | | | | | | |
| | | | | | | | | | | | |

* Employment pick list

- Student
- Schools or school system includes EI programs, elementary and secondary
- Post-secondary setting
- Government agency
- Clinical health care setting (includes hospitals, heath centers and clinics)
- Private sector
- Other (specify)

** The term “underserved” refers to “Medically Underserved Areas and Medically Underserved Populations with shortages of primary medical care, dental or mental health providers. Populations may be defined by geographic (a county or service area) or demographic (low income, Medicaid-eligible populations, cultural and/or linguistic access barriers to primary medical care services) factors. The term "vulnerable groups," refers to social groups with increased relative risk (i.e. exposure to risk factors) or susceptibility to health-related problems. This vulnerability is evidenced in higher comparative mortality rates, lower life expectancy, reduced access to care, and diminished quality of life.

Vulnerable Groups refers to social groups with increased relative risk (i.e. exposure to risk factors) or susceptibility to health-related problems. This vulnerability is evidenced in higher comparative mortality rates, lower life expectancy, reduced access to care, and diminished quality of life. (i.e, Immigrant Populations Tribal Populations, Migrant Populations, Uninsured Populations, Individuals Who Have Experienced Family Violence, Homeless, Foster Care, HIV/AIDS, etc)
*Source: Center for Vulnerable Populations Research. UCLA. http://www.nursing.ucla.edu/orgs/cvpr/who-are-vulnerable.html*

**MCH TRAINING PROGRAM GRADUATE FOLLOW-UP QUESTIONS**

**Contact / Background Information**

***Name** (first, middle, last): _____
**Previous Name** (if used while enrolled in the training program): _____
***Address**: _____

_____
City State Zip

**Phone**: _____
**Primary Email**: _____

***Permanent* Contact Information** (someone at a different address who will know how to contact you in the future, e.g., parents)

***Name of Contact**: _____
**Relationship**: _____
***Address**: _____

_____
City State Zip

**Phone**: _____

**What year did you graduate/complete the MCH Training Program**? _____

***Degree(s) earned while participating in the MCH Training Program*** _____*(a pick list will be provided-same as the one provided in the EHB faculty information form)*

***Ethnicity***: (choose one)
*Hispanic* is an ethnic category for people whose origins are in the Spanish-speaking countries of Latin America or who identify with a Spanish-speaking culture. Individuals who are Hispanic may be of any race.
__ **Hispanic**
__ **Not Hispanic**

***Race***: (choose one)
__ **American Indian and Alaskan Native** refer to people having origins in any of the original peoples of North and South America (including Central America), and who maintain tribal affiliation or community attachment. Tribe: _____
__ **Asian** refers to people having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent (e.g. Asian Indian).
__ **Black or African American** refers to people having origins in any of the Black racial groups of Africa.
__ **Native Hawaiian and Other Pacific Islander** refers to people having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.
__ **White** refers to people having origins in any of the original peoples of Europe, the Middle East, or North Africa.
__ **More than One Race** includes individuals who identify with more than one racial designation.
__ **Unrecorded** is included for individuals who do not indicate their racial category.

**Survey**
Please answer all of the following questions as thoroughly as possible. When you have filled out the entire survey, return it to your Center/Program.

**1. What best describes your current employment setting:**
__ Student
__ Schools or school system (includes EI programs, elementary and secondary)
__ Post-secondary setting
__ Government agency
__ Chealth care setting (includes hospitals, health centers and clinics)
__ Private sector
__ Other: please specify: _____

**2. Do you currently work in a public health organization or agency (including Title V)? Y/N**

**3. Does your current work relate to Maternal and Child Health (MCH) populations (**(i.e. women, infants and children, adolescents, and their families including fathers and children and youth with special health care needs,)?
__ yes
__ no

**4. Does your current work relate to underserved or vulnerable[10] populations** (i.e, Immigrant Populations Tribal Populations, Migrant Populations, Uninsured Populations, Individuals Who Have Experienced Family Violence, Homeless, Foster Care, HIV/AIDS, health disparities, etc)
__ yes
__ no

**5. Have you done any of the following activities since completing your training program?**

__ a. Participated on any of the following as a group leader, initiator, key contributor or in a position of influence/authority: committees of state, national or local organizations; task forces; community boards; advocacy groups; research societies; professional societies; etc.

__ b. Served in a clinical position of influence (e.g. director, senior therapist, team leader, etc.)

__ c. Provided consultation or technical assistance in MCH areas

__ d. Taught/mentored in my discipline or other MCH related field

__ e. Conducted research or quality improvement on MCH issues

[10] The term "underserved" refers to "Medically Underserved Areas and Medically Underserved Populations with shortages of primary medical care, dental or mental health providers. Populations may be defined by geographic (a county or service area) or demographic (low income, Medicaid-eligible populations, cultural and/or linguistic access barriers to primary medical care services) factors. The term "vulnerable groups," refers to social groups with increased relative risk (i.e. exposure to risk factors) or susceptibility to health-related problems. This vulnerability is evidenced in higher comparative mortality rates, lower life expectancy, reduced access to care, and diminished quality of life.

Vulnerable Groups refers to social groups with increased relative risk (i.e. exposure to risk factors) or susceptibility to health-related problems. This vulnerability is evidenced in higher comparative mortality rates, lower life expectancy, reduced access to care, and diminished quality of life. (i.e, Immigrant Populations Tribal Populations, Migrant Populations, Uninsured Populations, Individuals Who Have Experienced Family Violence, Homeless, Foster Care, HIV/AIDS, etc) *Source: Center for Vulnerable Populations Research. UCLA.* *http://www.nursing.ucla.edu/orgs/cvpr/who-are-vulnerable.html*

__ f. Disseminated information on MCH Issues (e.g., Peer reviewed publications, key presentations, training manuals, issue briefs, best practices documents, standards of care)

__ g. Served as a reviewer (e.g., for a journal, conference abstracts, grant, quality assurance process) (ac, c)

__ h. Procured grant and other funding in MCH areas

__ i. Conducted strategic planning or program evaluation

__ j. Participated in public policy development activities (e.g., Participated in community engagement or coalition building efforts, written policy or guidelines, influenced MCH related legislation (provided testimony, educated legislators, etc))

__ k. None

**6. If you checked <u>any</u> of the activities above, in which of the following settings or capacities would you say these activities occurred? (*check all that apply*)**

__ a. Academic
__ b. Clinical
__ c. Public Health
__ d. Public Policy & Advocacy

**(end of survey)**

***<u>Confidentiality Statement</u>***

Thank you for agreeing to provide information that will enable your training program to track your training experience and follow up with you after the completion of your training. Your input is critical to our own improvement efforts and our compliance with Federal reporting requirements. Please know that your participation in providing information is entirely voluntary. The information you provide will only be used for monitoring and improvement of the training program. Please also be assured that we take the confidentiality of your personal information very seriously. We very much appreciate your time and assistance in helping to document outcomes of the Training Program. We look forward to learning about your academic and professional development.

## Medium Term Trainees

DEFINITION: Medium term trainees are trainees with 40 - 299 contact hours in the current reporting year.

**Medium-term Trainees with 40-149 contact hours during the past 12-month grant period**

**Total Number _____**

**Disciplines (check all that apply):**

- ☐ Audiology
- ☐ Dentistry-Pediatric
- ☐ Dentistry – Other
- ☐ Education/Special Education
- ☐ Family/Parent/Youth Advocacy
- ☐ Genetics/Genetic Counseling
- ☐ Health Administration
- ☐ Medicine-General
- ☐ Medicine-Adolescent Medicine
- ☐ Medicine-Developmental-Behavioral Pediatrics
- ☐ Medicine-Neurodevelopmental Disabilities
- ☐ Medicine-Pediatrics
- ☐ Medicine-Pediatric Pulmonology
- ☐ Medicine – Other
- ☐ Nursing-General
- ☐ Nursing-Family/Pediatric Nurse Practitioner
- ☐ Nursing-Midwife
- ☐ Nursing – Other
- ☐ Nutrition
- ☐ Occupational Therapy
- ☐ Parent
- ☐ Physical Therapy
- ☐ Psychiatry
- ☐ Psychology
- ☐ Public Health
- ☐ Respiratory Therapy
- ☐ Social Work
- ☐ Speech-Language Pathology
- ☐ Other (Specify)

**Medium Term Trainees with 150-299 contact hours**

The totals for gender, ethnicity, race and discipline must equal the total number of medium term trainees with 150-299 contact hours

**Total Number** _____

| | | |
|---|---|---|
| **Gender** *(number not percent)* | Male _____ | Female _____ |
| **Ethnicity** *(number not percent)* | Hispanic: _____ | Not Hispanic _____ |
| **Race** *(number not percent)* | American Indian or Alaska Native: _____<br>Asian: _____<br>Black or African American: _____<br>Native Hawaiian or Other Pacific Islander: _____<br>White: _____<br>More than One Race: _____<br>Unrecorded:_____ | |

**Discipline**

| **Number** | **Discipline** |
|---|---|
| ____ | Audiology |
| ____ | Dentistry-Pediatric |
| ____ | Dentistry – Other |
| ____ | Education/Special Education |
| ____ | Family/Parent/Youth Advocacy |
| ____ | Genetics/Genetic Counseling |
| ____ | Health Administration |
| ____ | Medicine-General |
| ____ | Medicine-Adolescent Medicine |
| ____ | Medicine-Developmental-Behavioral Pediatrics |
| ____ | Medicine-Neurodevelopmental Disabilities |
| ____ | Medicine-Pediatrics |
| ____ | Medicine-Pediatric Pulmonology |
| ____ | Medicine – Other |
| ____ | Nursing-General |
| ____ | Nursing-Family/Pediatric Nurse Practitioner |
| ____ | Nursing-Midwife |
| ____ | Nursing – Other |
| ____ | Nutrition |
| ____ | Occupational Therapy |
| ____ | Parent |
| ____ | Physical Therapy |
| ____ | Psychiatry |
| ____ | Psychology |
| ____ | Public Health |
| ____ | Respiratory Therapy |
| ____ | Social Work |
| ____ | Speech-Language Pathology |
| ____ | Other (Specify)_____ |

**TOTAL Number of Medium term Trainees**: _____

**Short Term Trainees**

DEFINITION: Short-term trainees are trainees with less than 40 contact hours in the current reporting year. (Continuing Education participants are not counted in this category)

Total number of short term trainees during the past 12-month grant period_____

Indicate disciplines (check all that apply)

☐ Audiology
☐ Dentistry-Pediatric
☐ Dentistry – Other
☐ Education/Special Education
☐ Family/Parent/Youth Advocacy
☐ Genetics/Genetic Counseling
☐ Health Administration
☐ Medicine-General
☐ Medicine-Adolescent Medicine
☐ Medicine-Developmental-Behavioral Pediatrics
☐ Medicine-Neurodevelopmental Disabilities
☐ Medicine-Pediatrics
☐ Medicine-Pediatric Pulmonology
☐ Medicine – Other
☐ Nursing-General
☐ Nursing-Family/Pediatric Nurse Practitioner
☐ Nursing-Midwife
☐ Nursing – Other
☐ Nutrition
☐ Occupational Therapy
☐ Parent
☐ Physical Therapy
☐ Psychiatry
☐ Psychology
☐ Public Health
☐ Respiratory Therapy
☐ Social Work
☐ Speech-Language Pathology
☐ Other (Specify)

## Technical Assistance/Collaboration Form

DEFINITION: Technical Assistance/Collaboration refers to mutual problem solving and collaboration on a range of issues, which may include program development, clinical services, collaboration, program evaluation, needs assessment, and policy & guidelines formulation. It may include administrative services, site visitation and review/advisory functions. Collaborative partners might include State or local health agencies, and education or social service agencies. Faculty may serve on advisory boards to develop &/or review policies at the local, State, regional, national or international levels. The technical assistance (TA) effort may be a one-time or on-going activity of brief or extended frequency. The intent of the measure is to illustrate the reach of the training program beyond trainees.

Provide the following summary information on the **ALL** TA provided

| **Total Number of Technical Assistance/Collaboration Activities** | **TA Activities by Type of Recipient** | **Number of TA Activities by Target Audience** |
|---|---|---|
| _____ | ☐ Other Divisions/ Departments in a University<br>☐ Title V (MCH Programs)<br>☐ State Health Dept.<br>☐ Health Insurance/ Organization<br>☐ Education<br>☐ Medicaid agency<br>☐ Social Service Agency<br>☐ Mental Health Agency<br>☐ Juvenile Justice or other Legal Entity<br>☐ State Adolescent Health<br>☐ Developmental Disability Agency<br>☐ Early Intervention<br>☐ Other Govt. Agencies<br>☐ Mixed Agencies<br>☐ Professional Organizations/Associations<br>☐ Family and/or Consumer Group<br>☐ Foundations<br>☐ Clinical Programs/ Hospitals<br>☐ Other Please Specify | Local _____<br>Within State _____<br>Another State _____<br>Regional _____<br>National _____<br>International _____ |

**B.** Provide information below on the **5-10 most significant** technical assistance/collaborative activities in the past year. In the notes, briefly state why these were the most significant TA events.

| Title | Topic of Technical Assistance/Collaboration<br>*Select one from list A and all that apply from List B.* | | Recipient of TA/Collaborator | Intensity of TA | Primary Target Audience |
|---|---|---|---|---|---|
| | List A (select one)<br><br>A. Clinical care related (including medical home)<br>B. Cultural Competence Related<br>C. Data, Research, Evaluation Methods (Knowledge Translation)<br>D. Family Involvement<br>E. Interdisciplinary Teaming<br>F. Healthcare Workforce Leadership<br>G. Policy<br>H. Prevention<br>I. Systems Development/ Improvement | List B (select all that apply)<br><br>1. Women's/Reproductive/ Perinatal Health<br>2. Early Childhood Health/ Development (birth to school age)<br>**3.** School Age Children<br>4. Adolescent<br>5. CSHCN/Developmental Disabilities<br>6. Autism<br>7. Emergency Preparedness<br>8. Health Information Technology<br>9. Mental Health<br>10. Nutrition<br>11. Oral Health<br>12. Patient Safety<br>13. Respiratory Disease<br>14. Vulnerable Populations*****<br>15. Racial and Ethnic Diversity or Disparities<br>16. Other | a. Other Divisions/ Departments in a University<br>b. Title V (MCH Programs)<br>c. State Health Dept.<br>d. Health Insurance/ Organization<br>e. Education<br>f. Medicaid agency<br>g. Social Service Agency<br>h. Mental Health Agency<br>i. Juvenile Justice or other Legal Entity<br>j. State Adolescent Health<br>k. Developmental Disability Agency<br>l. Early Intervention<br>m. Other Govt. Agencies<br>n. Mixed Agencies<br>o. Professional Organizations/Associations<br>p. Family and/or Consumer Group<br>q. Foundations<br>r. Clinical Programs/ Hospitals<br>s. Other (specify) | 1. One time brief (single contact)<br>2. One time extended (multi-day contact provided one time)<br>3. On-going infrequent (3 or less contacts per year)<br>4. On-going frequent (more than 3 contacts per year) | 1. Local<br>2. Within State<br>3. Another State<br>4. Regional<br>5. National<br>6. International |
| 1 Example | G- Policy | 11- Oral Health | E - Education | 2 | 2 |

"Vulnerable groups," refers to social groups with increased relative risk (i.e. exposure to risk factors) or susceptibility to health-related problems. This vulnerability is evidenced in higher comparative mortality rates, lower life expectancy, reduced access to care, and diminished quality of life.

**C.** In the past year have you provided technical assistance on emerging issues that are not represented in the topic list above? YES/ NO.

If yes, specify the topic(s):_____

## Continuing Education Form

Continuing Education is defined as continuing education programs or trainings that serve to enhance the knowledge and/or maintain the credentials and licensure of professional providers. Training may also serve to enhance the knowledge base of community outreach workers, families, and other members who directly serve the community.

**A.** Provide information related to the total number of CE activities provided through your training program last year.

Total Number of CE Participants _____
Total Number of CE Sessions/Activities _____

Number of CE Sessions/Activities by Primary Target Audience
- Number of **Local** CE Activities _____
- Number of **State** CE Activities _____
- Number of CE Activities in **Another State** _____
- Number of **Regional** CE Activities _____
- Number of **National** CE Activities
- Number of **International** CE Activities _____

_____

Number of CE Sessions/Activities for which Credits are Provided _____

For **up to 10** of the most significant CE activities in the past project year, list the title, topics, methods, number of participants, duration and whether CE units were provided. In the field notes, briefly state why these were the most significant CE events (e.g., most participants reached; key topic addressed, new collaboration opportunity, emerging issues, diversity of participants (other than healthcare workers etc))

| **Title** | **Topic: List A** select one | **Topic: List B:** *select all that apply* | **Primary Target Audience** | **Method*** | **Number of Participants** | **Continuing Education Credits Provided?** (Yes/No) |
|---|---|---|---|---|---|---|
| | A. Clinical Care-Related (including medical home)<br>B. Cultural Competence-Related<br>C. Data, Research, Evaluation Methods (Knowledge Translation)<br>D. Family Involvement<br>E. Interdisciplinary Teaming<br>F. Healthcare Workforce Leadership<br>G. Policy<br>H. Prevention<br>I. Systems Development/ Improvement | 1. Women's Reproductive/ Perinatal Health<br>2. Early Childhood Health/ Development (birth to school age)<br>3. School Age Children<br>4. Adolescent<br>5. CSHCN/Developmental Disabilities<br>6. Autism<br>7. Emergency Preparedness<br>8. Health Information Technology<br>9. Mental Health<br>10. Nutrition<br>11. Oral Health<br>12. Patient Safety<br>13. Respiratory Disease<br>14. Vulnerable Populations*****<br>15. Racial and Ethnic Diversity or Disparities<br>16. Other (specify) | 1. Local<br>2. State<br>3. Another state<br>4. Regional<br>5. National<br>6. International | A. In-person<br>B. Distance<br>C. Mixed | | |
| 1. | | | | | | |
| 2. | | | | | | |
| 3. | | | | | | |

* "Vulnerable groups" refers to social groups with increased relative risk (i.e. exposure to risk factors) or susceptibility to health-related problems. This vulnerability is evidenced in higher comparative mortality rates, lower life expectancy, reduced access to care, and diminished quality of life. Center for Vulnerable Populations Research. UCLA. *http://www.nursing.ucla.edu/orgs/cvpr/who-are-vulnerable.html*

**C.** In the past year have you provided continuing education on emerging issues that are not represented in the topic list above? YES/ NO. If yes, specify the topic(s):_____

## Products, Publications and Submissions Data Collection Form

**Part 1**

Instructions: Please list the number of products, publications and submissions addressing maternal and child health that have been published or produced by your staff during the reporting period (counting the original completed product or publication developed, not each time it is disseminated or presented). Products and Publications include the following types:

| Type | Number |
|---|---|
| Peer-reviewed publications in scholarly journals – published (including peer-reviewed journal commentaries or supplements) | |
| Peer-reviewed publications in scholarly journals – submitted | |
| Books | |
| Book chapters | |
| Reports and monographs (including policy briefs and best practices reports) | |
| Conference presentations and posters presented | |
| Web-based products (Blogs, podcasts, Web-based video clips, wikis, RSS feeds, news aggregators, social networking sites) | |
| Electronic products (CD-ROMs, DVDs, audio or videotapes) | |
| Press communications (TV/Radio interviews, newspaper interviews, public service announcements, and editorial articles) | |
| Newsletters (electronic or print) | |
| Pamphlets, brochures, or fact sheets | |
| Academic course development | |
| Distance learning modules | |
| Doctoral dissertations/Master's theses | |
| Other | |

**Part 2**

Instructions: For each product, publication and submission listed in Part 1, complete all elements marked with an "*."

**Data collection form: Peer-reviewed publications in scholarly journals – published**

*Title: _____

*Author(s): _____

*Publication: _____

*Volume: _____ *Number: _____ Supplement: _____ *Year: _____ *Page(s):_____

*Target Audience: Consumers/Families ___ Professionals ___ Policymakers ___ Students ____

*To obtain copies (URL): _____

Key Words (No more than 5): _____

Notes: _____

**Data collection form: Peer-reviewed publications in scholarly journals – submitted**

*Title: _____

*Author(s): _____

*Publication: _____

*Year Submitted: _____

*Target Audience: Consumers/Families ___ Professionals ___ Policymakers ___ Students ____

Key Words (No more than 5): _____

Notes: _____

**Data collection form: Books**

*Title: _____

*Author(s): _____

*Publisher: _____

*Year Published: _____

*Target Audience: Consumers/Families ___ Professionals ___ Policymakers ___ Students ____

Key Words (No more than 5): _____

Notes: _____

**Data collection form for: Book chapters**

Note: If multiple chapters are developed for the same book, list them separately.

*Chapter Title: _____

*Chapter Author(s): _____

*Book Title: _____

*Book Author(s): _____

*Publisher: _____

*Year Published: _____

*Target Audience: Consumers/Families ___ Professionals ___ Policymakers ___ Students ____

Key Words (no more than 5): _____

Notes: _____

**Data collection form: Reports and monographs**

*Title: _____

*Author(s)/Organization(s): _____

*Year Published: _____

*Target Audience: Consumers/Families ___ Professionals ___ Policymakers ___ Students ____

*To obtain copies (URL or email): _____

Key Words (no more than 5): _____

Notes: _____

**Data collection form: Conference presentations and posters presented**

(This section is not required for MCHB Training grantees.)

*Title: _____

*Author(s)/Organization(s): _____

*Meeting/Conference Name: _____

*Year Presented: _____

*Type: ☐ Presentation ☐ Poster

*Target Audience: Consumers/Families ___ Professionals ___ Policymakers ___ Students ____

*To obtain copies (URL or email): _____

Key Words (no more than 5): _____

Notes: _____

**Data collection form: Web-based products**

*Product: _____

*Year: _____

*Type: ☐ blogs ☐ podcasts ☐ Web-based video clips
☐ wikis ☐ RSS feeds news aggregators
☐ social networking sites ☐ Other (Specify)

*Target Audience: Consumers/Families ___ Professionals ___ Policymakers ___ Students ____

*To obtain copies (URL): _____

Key Words (no more than 5): _____

Notes: _____

**Data collection form: Electronic Products**

*Title: _____

*Author(s)/Organization(s): _____

*Year: _____

*Type: ☐ CD-ROMs ☐ DVDs ☐ audio tapes
☐ videotapes ☐ Other (Specify)

*Target Audience: Consumers/Families ___ Professionals ___ Policymakers ___ Students ____

*To obtain copies (URL or email): _____

Key Words (no more than 5): _____

Notes: _____

**Data collection form: Press Communications**

*Title: _____

*Author(s)/Organization(s): _____

*Year: _____

*Type: ☐ TV interview ☐ Radio interview ☐ Newspaper interview
☐ Public service ☐ Editorial article ☐ Other (Specify)

announcement

*Target Audience: Consumers/Families ___ Professionals ___ Policymakers ___ Students ____

*To obtain copies (URL or email): _____

Key Words (no more than 5): _____

Notes: _____

**Data collection form: Newsletters**

*Title: _____

*Author(s)/Organization(s): _____

*Year: _____

*Type: ☐ Electronic ☐ Print ☐ Both

*Target Audience: Consumers/Families ___ Professionals ___ Policymakers ___ Students ____

*To obtain copies (URL or email): _____

*Frequency of distribution: ☐ weekly ☐ monthly ☐ quarterly ☐ annually ☐ Other (Specify)

Number of subscribers: _____

Key Words (no more than 5): _____

Notes: _____

**Data collection form: Pamphlets, brochures or fact sheets**

*Title: _____

*Author(s)/Organization(s): _____

*Year: _____

*Type: ☐ Pamphlet ☐ Brochure ☐ Fact Sheet

*Target Audience: Consumers/Families ___ Professionals ___ Policymakers ___ Students ____

*To obtain copies (URL or email): _____

Key Words (no more than 5): _____

Notes: _____

**Data collection form: Academic course development**

*Title: _____

*Author(s)/Organization(s): _____

*Year: _____

*Target Audience: Consumers/Families ___ Professionals ___ Policymakers ___ Students ____

*To obtain copies (URL or email): _____

Key Words (no more than 5): _____

Notes: _____

**Data collection form: Distance learning modules**

*Title: _____

*Author(s)/Organization(s): _____

*Year: _____

*Media Type:

| | | |
|---|---|---|
| ☐ blogs | ☐ podcasts | ☐ Web-based video clips |
| ☐ wikis | ☐ RSS feeds | ☐ news aggregators |
| ☐ social networking sites | ☐ CD-ROMs | ☐ DVDs |
| ☐ audio tapes | ☐ videotapes | ☐ Other (Specify) |

*Target Audience: Consumers/Families ___ Professionals ___ Policymakers ___ Students ____

*To obtain copies (URL or email): _____

Key Words (no more than 5): _____

Notes: _____

**Data collection form: Doctoral dissertations/Master's theses**

*Title: _____

*Author: _____

*Year Completed: _____

*Type: ☐ Doctoral dissertation ☐ Master's thesis

*Target Audience: Consumers/Families ___ Professionals ___ Policymakers ___ Students ____

*To obtain copies (URL or email): _____

Key Words (no more than 5): _____

Notes: _____

**Other**

(Note, up to 3 may be entered)

*Title: _____

*Author(s)/Organization(s): _____

*Year: _____

*Describe product, publication or submission: _____

_____

*Target Audience: Consumers/Families ___ Professionals ___ Policymakers ___ Students ____

*To obtain copies (URL or email): _____

Key Words (no more than 5): _____

Notes: _____

# Appendix B: Trainee/Fellow Guidelines

## A. Definitions

1. A **trainee** is an individual whose activities within the training program are directed primarily toward achieving an advanced degree.

2. A **fellow** is an individual who has met at least the minimum standards of education and experience accepted by his/her respective profession and whose activities within the training program are for the primary purpose of obtaining or enhancing particular skills or knowledge.

## B. Qualifications

1. A **trainee** must have at least a baccalaureate degree and be enrolled in a graduate program.
2. A **fellow** must have achieved the academic degree and completed requisite training which constitutes the basic professional level training for his/her field.
3. A **postdoctoral** fellow must have an earned doctorate and must have completed any required internship.
4. A **special fellow** may be approved, upon request to the MCHB, only in those unusual circumstances where particular needs cannot be met within the categories described above.
5. **Citizenship** – A fellow or trainee must be a United States citizen, or, as an alien, must have been admitted to the United States with a permanent resident visa.
6. **Licensure** – For any profession for which licensure is a prerequisite, the applicant must also be licensed by one of the states, or, in the case of foreign graduates, meet other requirements which legally qualify him/her to practice his/her profession in the United States.

## C. Restrictions

1. **Concurrent Income**
   It is expected that most trainees/fellows will be full time. In most instances stipends may not be granted to persons receiving a concurrent salary, fellowship or traineeship stipend, or other financial support related to his/her training or employment. In the case of part-time trainees/fellows, exceptions may be requested and will be considered on an individual basis. Tuition support may be provided to full-time or part-time trainees.

2. **Non-related Duties**
   The training institution shall not require trainees or fellows to perform any duties which are not directly related to the purpose of the training for which the grant was awarded.

**3. Field Training**

Training institutions may not utilize grant funds to support field training, except when such training is part of the specified requirements of a degree program, or is authorized in the approved application.

**4. Other**

Grant funds may **not** be used: (a) for the support of any trainee who would not, in the judgment of the institution, be able to use the training or meet the minimum qualifications specified in the approved plan for the training; (b) to continue the support of a trainee who has failed to demonstrate satisfactory participation; or (c) for support of candidates for undergraduate or pre-professional degrees, or the basic professional degree.

## D. Trainee Costs

**1. Allowable Costs**

a. Stipends
b. Tuition and fees, including medical insurance
c. Travel related to training and field placements
d. For a few institutions it is beneficial to support trainees through tuition remission and wages. Tuition remission and other forms of compensation paid as, or in lieu of, wages to students (including fellows and trainees) performing necessary work are allowable provided that there is a bona fide employer-employee relationship between the student and the institution for the work performed, the tuition or other payments are reasonable compensation for the work performed and are conditioned explicitly upon the performance of necessary work, and it is the institution's practice to similarly compensate students in non-sponsored as well as sponsored activities.

**2. Non-Allowable Costs**

a. Dependency allowances
b. Travel between home and training site, unless specifically authorized
c. Fringe benefits or deductions which normally apply only to persons with the status of an employee

**3. Stipend Levels**

All stipends indicated are for a full calendar year, and must be prorated for an academic year or other training period of less than twelve months. The stipend levels may, for the Maternal and Child Health Training Program, be treated as ceilings rather than mandatory amounts, i.e., **stipends may be less than but may not exceed the amounts indicated**. However, where lesser amounts are awarded the awarding institution must have established, written policy which identifies the basis or bases for such variation and which ensures equitable treatment for all eligible trainees/fellows. These stipend levels apply to the National Institutes of Health, the Agency for Healthcare Research and Quality, and the Health Resources and Services Administration training grantees and were updated on January 20, 2012, see http://grants.nih.gov/grants/guide/notice-files/NOT-OD-12-033.html.

The stipend levels are as follows:

| **Career Level** | | **Stipend for FY 2012** |
|---|---|---|
| | | |
| **Undergraduates in the MARC and COR Programs:** | | |
| Freshmen/Sophomores | | $8,304 |
| Juniors/Seniors | | $11,628 |
| | | |
| **Pre-doctoral** | | $22,032 |
| | | |
| **Postdoctoral** | | |
| Years of Experience: | | |
| | 0 | $39,264 |
| | 1 | $41,364 |
| | 2 | $44,340 |
| | 3 | $46,092 |
| | 4 | $47,820 |
| | 5 | $49,884 |
| | 6 | $51,582 |
| | 7 or more | $54,180 |

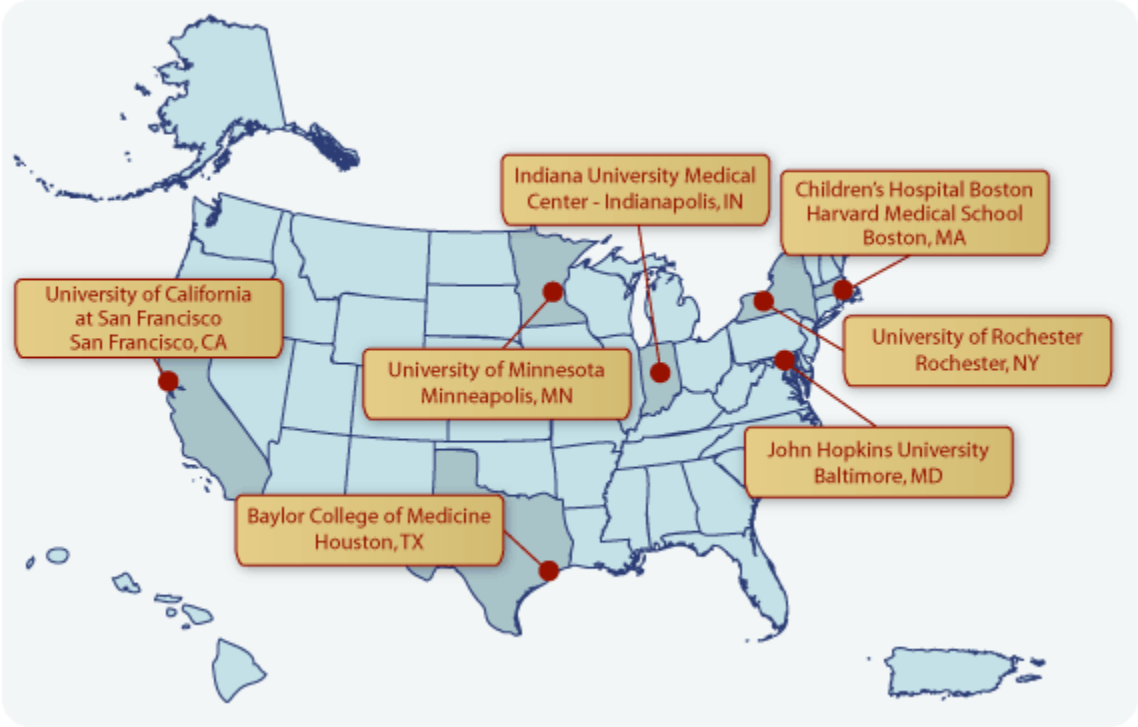
*Determination of the "years of relevant experience" shall be made in accordance with program guidelines and will give credit to experience gained prior to entry into the grant-supported program as well as to prior years of participation in the grant-supported program. The appropriate number of "years" (of relevant experience) at the time of entry into the program will be determined as of the date on which the individual trainee begins his/her training rather than on the budget period beginning date of the training grant. Stipends for subsequent years of support are at the next level on the stipend chart.

**b. Supplements to Stipends**

Stipends specified above may be supplemented by an institution from non-federal funds. No Federal funds may be used for stipend supplementation unless specifically authorized under the terms of the program from which the supplemental funds are derived.

# APPENDIX C: MCH LEAH Training Grants by State

## Map of Current LEAH Training Grants




- Baylor College of Medicine - Houston, TX
- Children's Hospital Boston - Boston, MA
- Indiana University Medical Center - Indianapolis, IN
- Johns Hopkins University - Baltimore, MD
- University of California at San Francisco - San Francisco, CA
- University of Minnesota - Minneapolis, MN
- University of Rochester - Rochester, NY